Lecture
ON
LITHOTRITY AT A SINGLE SITTING.

WITH ADDITIONS, AND AN ANALYSIS OF 101 CASES.

Delivered at University College Hospital, Nov. 21st, 1880,

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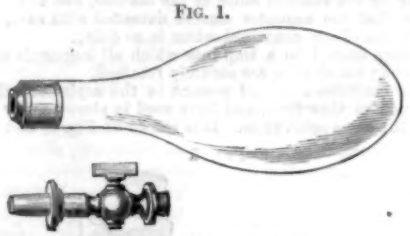
GENTLEMEN,—I have always thought it desirable to commence my lectures on Lithotrity by sketching its brief history—one which differs so widely from that of lithotomy, dating backwards as the latter does some twenty centuries at least. And the rule seems still to be desirable; indeed, perhaps, more so than ever.

The first efforts to crush a stone were made early in the present century, and culminated in the first performance of the operation by Civiale in 1824. After a considerable interval, during which the operation underwent many modifications in the hands of several French surgeons, and not necessary now to be described, a proposal was made by Heurteloup to remove débris on a large scale and accomplish the task at a single operation; but in this he did not succeed.[1] Before this Sir P. Crampton, of Dublin, had invented an apparatus, consisting of a glass receiver, like a large soda-water bottle, from which, by means of an exhausting syringe, he removed the air, and then applied it to a large silver evacuating catheter previously introduced into the bladder.[2] Into this cavity some twelve or fourteen ounces of water had been injected, so that on turning a tap attached to the receiver a powerful rush into it of water and débris took place. This was the first "aspirator." (Fig. 1.) Sir Philip was good enough to pre-

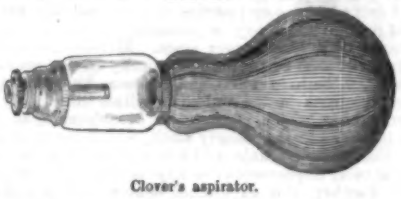
FIG. 1.



Sir Philip Crampton's aspirator.

sent me in the year 1854 with a specimen of the instrument, and I tried it, but found it dangerously rough in action, and requiring to be so repeatedly charged and applied that I dared not use it. Soon afterwards Mr. Clover designed an india-rubber aspirator with a glass cylinder, trapped to prevent reflux of fragments, which answered its purpose exceedingly well. The evacuating catheters were silver, Nos. 12 and 13 in size. (Fig. 2.) This apparatus was much

FIG. 2.



Clover's aspirator.

used by myself to supplement the action of the bladder, on which action, together with washing out by a forcible current from the eight-ounce syringe, most surgeons (Skey and Coulson particularly) had relied for removing some of the débris made at each sitting. Meanwhile Civiale, who was about this time (1845-65) the most experienced operator in Europe, strongly enjoined the principle of trusting mainly to the natural expulsive power of the bladder, and, shunning anæsthesia, abjured the use of any other instruments except those for thoroughly crushing, as injurious to the organs involved. The same practice was pursued here by Sir B. Brodie, who had a considerable experience, and whose well-known care and judgment conduced to the success of the method. But this over-cautious procedure, as it has turned out to be, doubtless retarded considerably the improvement of the crushing operation. During a somewhat later period, however, Sir William Fergusson was endeavouring to shorten the procedure by removing much débris by the lithotrite itself, introducing it many times during a long sitting under ether; and he succeeded thus in emptying a bladder of a medium-sized calculus at one operation—not, however, without sometimes inflicting serious injury on the neck of the bladder and urethra, by withdrawing large and rough fragments. Lastly, I must add that long before 1870 I was freely using Clover's apparatus for removing débris,[3] subsequently advocating and employing larger crushings, and evacuating by means of it all the débris, however much might remain, when the patient had severe cystitis due to the presence of large or sharp fragments in the bladder. This system I strongly enjoined both here and abroad, where especially the waiting and soothing treatment has been pursued in these circumstances, and application of the lithotrite postponed, in obedience to the powerful traditions of Civiale's teaching.

In 1878 an important change was proposed, as is well known, by Professor Bigelow. He advised that the stone, however large, and without respect to the presence of cystitis or other considerations, should be invariably removed at one sitting, by means of more powerful lithotrites, larger evacuating catheters, and a stronger india-rubber bottle than had before been used. The condition necessary and preliminary to this proposal had been the adoption of a doctrine taught by Otis, of New York, that the ordinary male urethra might be treated as capable of fairly admitting instruments of 16 or 18 gauge, English, or Nos. 20, 30, French; instead of Nos. 12, 14, English, 22, 25, French, which had been generally regarded in the two countries as about the limits of safety in dealing with an ordinary healthy urethra. Once satisfied that the canal would safely admit the larger instruments under the influence of ether, there was no longer reason why a large and hard stone should not be removed, so far as the mechanical procedure is concerned, at one operation. Bigelow believed that it

[1] It is interesting to observe how completely Heurteloup was impressed with the necessity for removing all the calculous matter at a single sitting: the italics are Heurteloup's: "Mon but, jusqu'à présent, messieurs, a été de mettre sous vos yeux les moyens que se proposait la lithotripsie en tant que se bornant à briser la pierre et laissant à la nature l'expulsion des fragments ou de la poudre. Mais, tant qu'elle n'est pas arrivée à guérir promptement les malades, elle est imparfaite, et c'est pour arriver à sa perfection que je me propose de vous soumettre d'autres travaux. Dans des travaux subsequents je traiterai des procédés par lesquels la lithotripsie peut arriver à remplir ses deux buts finals: *l'extraction immédiate et complète* des pierres et leur *pulvérisation immédiate et complète*. J'essayerai de vous démontrer, dans la partie qui traitera de *l'extraction immédiate et complète*, que c'est une grande faute, en lithotripsie, de briser une petite pierre dans la vessie et de laisser dans l'organe les fragments qui peuvent s'y perdre dans les *sinus* et les *anfractuosités* de la membrane, sinus et anfractuosités qui sont souvent, comme vous le savez, profonds et fréquents. Je vous démontrerai qu'il faut extraire ces petites pierres et renvoyer immédiatement la malade guéri. Vous voyez que, sous le rapport des pierres peu volumineuses, nous sommes bien loin des procédés primitifs et élémentaires que nous avons passés en revue."—"L'Art de Broyer les Pierres," a memoir read to the Academy of Medicine of Paris, 1857. Heurteloup, however, appears never to have realised his idea in practice.

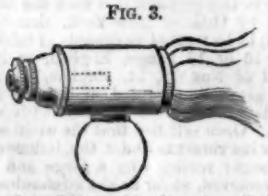
[2] Dublin Quarterly Journal, February, 1846, pp. 22 and 43. Drawn and described in the Enlarged Prostate, by Sir H. Thompson. London, 1857. pp. 297-9.

[3] In the second edition of my Lithotomy and Lithotrity, 1870, published exactly twelve years ago, I state that I have used Clover's apparatus for removing fragments some 200 or 300 times (p. 215), and that I have used no other means but it, in addition to the lithotrite, for some years (p. 208). I have there also given special directions for the best mode of using it, recommending silver evacuating catheters, "as large as the urethra will admit," with full-sized openings in them, both terminal and lateral. It seems necessary to revert to these facts, as attempts have been recently made not only to undervalue the original aspirator of Clover, but to represent it as a useless and therefore unused instrument. My own experience of its value, which largely increased after the date referred to above, incontrovertibly proves the contrary; and in justice to Mr. Clover mainly, as well as to myself, I feel compelled to make this statement.

would be safer to empty the bladder, even at the cost of manipulations much more prolonged and severe than had been deemed practicable, than to operate by several sittings with fragments left in the bladder during the intervals of operating. This method has now been employed by several operators, both English and American, but at present has not been generally accepted on the Continent. I tested it without delay in my own practice at the outset, and my own views of its capability may be gathered from the fact that I have employed it largely ever since. Moreover, as early as the autumn of 1880 I had the opportunity of demonstrating the procedure, both in Paris and Vienna, by operating on calculous patients in the public hospitals there. My own experience of it, which is therefore considerable, amounts now to 101 cases in the elderly adult, which have occurred in 101 different individuals, and I do not hesitate to regard it as a valuable improvement on any method previously employed. Further, this experience enables me to place on record not only the results in relation to the all-important question of mortality, but also in some degree to the condition of the patients subsequent to operation, a question which is only second to the former in importance. But I will first describe the various steps of the operation, and show you the instruments which I think the best with which to perform it, and with which I have attained the results referred to. And here I shall revert to the axiom I laid down at my opening lecture, that in the treatment of all diseases of the urinary passages, first, your instruments should be as simple in construction as possible; secondly, that they should be used as sparingly, and always as gently, as the necessities of each case admit of. By lightness and suppleness of handling, much more may be accomplished than by simple force, while risk is for the same reason avoided.

[The subject of sounding and finding the stone, so often missed by inefficient methods of searching, followed, after which the lecturer proceeded as follows]:—In operating by one sitting instead of several sittings, I am happy to tell you that no very great changes in the armamentarium are necessary. The work to be done is precisely the same as that we have always done before; the only difference is that larger stones may be attacked, and, as much larger quantities are to be removed, there is more work and harder work to be done than formerly. A stouter lithotrite, and one which will bite well into a hard stone and break it into fragments first, which by means of a less powerful but more easy working lithotrite may be crushed into débris,[4] are mainly necessary. Hence several patterns of the old fenestrated instrument which had been discarded as too heavy under the previous system may now be brought into use again, if fitted with the cylindrical handle, which by almost universal consent is adopted as the most convenient. For the fenestrated instrument does not become blocked by crushing, the small fragments being driven through the opening in the female blade. The flat-bladed lithotrite, which hitherto has been much employed, should for this work be provided with a more sufficient opening in the female blade to prevent blocking, which renders it the most useful instrument in reducing fragments to débris adapted to pass a No. 15 or 16

FIG. 3.



Clover's aspirator, with glass trap attached.

evacuator. When a stone of medium size has been broken up, and by repeated crushings during some eight or ten minutes is obviously reduced, or nearly so, to débris, the lithotrite should be withdrawn, and an evacuating catheter, Nos. 15, 16 to 18, according to previous examination of the urethra, should be introduced into the bladder, when urine and some débris will be expelled. It is, of course, sometimes necessary to divide the external meatus, but this is a matter of no moment. To this catheter the aspirator, of which there are several varieties, is next to be applied. Mr. Clover's original instrument is still a useful one, made rather stronger than formerly, and it may have a cylindrical receiver at the bottom of it if desired. (See Fig. 3.) Professor Bigelow used as his first aspirator a strong large india-rubber bottle, from the top of which a long tube was attached to the catheter in the bladder, but he has modified this several times. A later form which he was good enough to show me, and which he exhibited last summer in London, is less simple in construction than any I should employ, although acting well with artificial fragments of uniform size in rigid vessels. The conditions under which we perform lithotrity in the human bladder, varying as it does every instant in size, and varying also in different individuals in regard to form, contractility, suppleness, &c., render experimental trials in rigid receptacles almost valueless, as I had occasion years ago to point out, being quite without analogy to the conditions of the organ in the living subject. Experience in the latter must guide us as to the best instruments of any kind to be used there. In designing a new aspirator at the outset for the one-sitting operation, I came to the conclusion that the following points are essential in the construction of an efficient instrument.

FIG. 4.

Original aspirator of Sir Henry Thompson.

1. It should be light and small, so as to be easily grasped and governed by one hand.

2. It should have an opening *at the top*, by which it can be filled with water, to which all air accidentally admitted, if any, will arise, and by which it can escape.

3. Its *lower part* should be connected with the evacuating catheter by the shortest route to the bladder, and in such a manner that the aspirator can be detached with ease, and without loss of any contained water in so doing.

4. There should be a trap into which all fragments must fall, and by which they are securely retained.

These conditions are all present in the aspirator which I designed at that time, and have used in almost every one of the 101 cases referred to. It is shown at Fig. 4, and was

FIG. 5.

Recent change in the situation of the trap.

first described in this country in THE LANCET of Jan. 17th, 1880.[5] Quite recently a little alteration has been suggested, as shown at Fig. 5, which is identical with Fig. 4 in every particular, except that the cylindrical receiver, which is in Fig. 3 directly under the bottle, and may be slightly in-

[4] It is desirable to use these terms, each with its own specific meaning. By "fragments" I intend the large portions first produced by breaking up the stone and which are too large to issue; by "débris," the smaller portions, the result of crushing, from the further use of the lithotrite.

[5] Previously described and figured for the first time by me in the Gazette Hebdomadaire of Paris in the preceding autumn.

fluenced by currents, is removed to the front of it, and is perhaps less disturbed by the current which passes over the mouth of the receiver. This change has been made by Messrs. Weiss and Son, and at their suggestion. In neither Fig. 4 nor Fig. 5 is any stand required, and the connexion with the bladder is the shortest and simplest possible. The connexion of the aspirator with the bladder is also cut off in both instruments by the taps T.

To continue the operation. The aspirator being attached to the evacuating catheter in the bladder, alternate pressure and expansion take place in obedience to the hand of the operator, who at the same time modifies the position of the catheter according to his judgment on observing the arrival of small fragments and débris in the trap. When much has come over, and the rattle and movement of fragments in the bladder have manifestly diminished, a large piece or two perhaps only being felt, which evidently cannot issue, the aspirator is removed, and a lithotrite introduced. If the fragments are not considerable, a flat-bladed instrument will probably dispose of the remainder; the aspirator is again applied, and the bladder is completely cleared. Of course if more stone remains, the process is repeated once or more. In from ten to forty or fifty minutes, however, a uric-acid calculus of very considerable size may be thus broken up and removed. Longer than fifty minutes I have never yet had occasion to prolong an operation.

Lecture

ON THE

HISTORY OF DISCOVERIES CONCERNING THE CIRCULATION OF THE BLOOD,

INTRODUCTORY TO THE COURSE OF PHYSIOLOGY,

Delivered in the University of Edinburgh, Oct. 28th, 1881,

BY WM. RUTHERFORD, M.D., F.R.S.,

PROFESSOR OF PHYSIOLOGY.

GENTLEMEN,—It has for some years past unfortunately become customary on the part of certain opponents of medical progress to systematically represent that nothing of any value has been learned from experiments on animals. These persons have been "heard because of their much speaking." By the frequent repetition of statements calculated to produce an erroneous impression upon those who have not been educated in biological science, they have succeeded in persuading many intelligent persons to believe their *false report*. It seems to me perfectly plain that we must not any longer merely trust the common sense of the public to perceive that they are being systematically misled by the enemies of science. We must trouble ourselves more than we have hitherto done to provide the public with a true account of the manner in which important physiological discoveries have been arrived at; and, as "truth is great and will ever prevail," I am sure that, if we put our case clearly, it will not fail to convince minds that are unprejudiced. I cannot in the course of an hour do more than allude to a limited part of Physiology, and I have chosen the Circulation of the Blood because that is a typical case from which the others may be judged.

It was long a prevalent idea among the ancients that the blood of the body is contained in the veins and right side of the heart, while the left side of the heart and arteries are filled with air derived from the lungs and distributed to all parts of the body to keep it cool. So completely did this idea—of blood in the *veins* only—occupy the minds of classic writers, that even now were anyone on some rhetorical occasion to say,—e.g., that Mr. Gladstone has Scottish blood in his *arteries*, he would be regarded as an iconoclast of classical phraseology. That old erroneous idea resulted from lack of knowledge regarding the many differences that exist between a *dead* and a *living* body. It is true that the blood to a large extent leaves the arteries at death and accumulates in the veins, and that when both sets of vessels are cut across after death, the thin-walled vein collapses, while the thick-walled artery remains patent and becomes filled with air by the elasticity of its wall. But it is equally true that until the artery is opened, there is no air in it, either during life or after death. In the time of Galen it came to be recognised that the arteries contain blood, but it took many a long century after him to discover that the arteries contain blood *without an admixture of air*. Galen was a Roman of the second century. He was the physician and friend of the great Emperor Marcus Aurelius. He was a man of much force of character, and an indefatigable investigator. His book on the "Uses of the Parts of the Body" is of great historical interest to the physiologist. It shows that Galen was always in his researches actuated by the conviction that "Nature does nothing in vain," and that every part of the body must have some utility. He dissected the dead, he experimented on living animals, and he watched the effects of diseased conditions which have, aptly enough, been designated the "experiments of nature." By observations made by these three methods he criticised the ideas of his predecessors, and advanced many new doctrines, some near the mark, many wide of it. It is not surprising that many of his theories should have turned out erroneous, for with a mechanism like the animal body, so complicated and difficult of comprehension, how could he, in the infancy of science, do otherwise than err greatly on many points which chemistry and other developments of modern science were needed to explain?

Galen's teaching with regard to the movement of the blood deserves our attention, for it lasted from the second until the seventeenth century, when it received its final blow from Harvey. Galen said, since the different parts of the animal body require to be nourished, Nature has provided the alimentary canal, a large channel common to all the nourishing materials, and a system of smaller channels—the vessels which convey the nutriment to all parts of the body. In the stomach the food undergoes a primary elaboration, and the material suitable for nourishment passes into the veins of the stomach and intestine, and thence by the vena porta to the liver, where it undergoes a second purification, the useless material being thrown away as the bile, and the remainder becoming "perfect blood." He compared the "liquid humour" found in the portal vein to the juice just expressed from the grape—which must undergo fermentation and refinement ere it becomes real wine. To Galen therefore the liver was a blood-making organ; it was the "fountain of the blood," which flowed away by the hepatic veins to the vena cava, to be conveyed to all parts of the body (*lib. cit.*, bk. i., ch. v.). According to Galen, the blood flows up the vena cava to the head, neck, and arms, and down that vessel to the lower parts of the body; and everywhere the tissues are nourished by blood brought to them by the *veins*. He regarded the right auricle of the heart as a sort of diverticulum from the vena cava, through which *some* of the blood passes from the vena cava into the right ventricle. From the right ventricle it takes two courses: part of it passes through the pulmonary artery to nourish the lungs, while the remainder passes through pores in the septum of the heart into the left ventricle. There it is mingled with air drawn from the lungs through the pulmonary veins, and the mixture of blood and air leaves the heart by the aorta to be distributed by the arteries to all the organs. So, said he, every organ is supplied with a vein, an artery, and a nerve; the blood in the vein nourishes it, the artery supplies it with vital spirits and keeps it cool, and the nerve gives it sensibility. Galen evidently thought that by getting the blood from the right to the left side of the heart through its partition wall he had triumphantly explained how it is that in the living animal there is blood in the *left* as well as in the *right* ventricle of the heart, and yet he was still in harmony with the doctrine of his teachers, that air passes from the lungs to the heart and arteries through the pulmonary veins.

But he started another unfortunate error, which was even in the seventeenth century supported by Riolan of Paris in opposition to Harvey. Galen stated that everywhere throughout the body the arteries and veins frequently anastomose by small openings, whereby an interchange of blood and air takes place (*lib. cit.*, bk. vi. ch. x.). With that idea we must return for a moment to the lung. Galen made the discovery that the pulmonary veins are not merely air-tubes, as previously supposed, but that they contain *blood* as well as air, and he accounted for the presence of the blood by supposing that it escapes from the pulmonary artery through his imaginary anastomoses between it and the pulmonary vein. He said that the blood is squeezed through

these minute openings by the contraction of the *chest*, "since the sigmoid valves at the orifice of the pulmonary artery prevent its reflux to the heart, where can it go when urged by the fall of the chest-wall but through the small side apertures between the pulmonary arteries and pulmonary veins?" Apparently Galen did not attach much importance to the blood in the pulmonary veins. It seems as if he thought it got into the veins by a sort of *side issue*. The imaginary pores in the septum of the heart appear to have been to him the great channels by which the blood reaches the left ventricle. Still it must be admitted that Galen very nearly discovered the pulmonary circulation. His teaching with regard to the heart and pulse is also of interest, for it encumbered physiology until Harvey showed its error. Hippocrates, and Galen five centuries later, compared the heart's action to that of the chest. As the chest moves up and down, inspiring and expelling air like a pair of bellows, in like manner the heart with its valves acts like bellows, forcibly *drawing* blood into its right, and *air* into its left, side, and then expelling both by the arteries. The *indrawing* of the blood and air, like the act of inspiration, was thought to be the more forcible of the two movements. Galen also regarded the pulsatile movements of arteries as a *bellows movement*, the artery drawing in blood and air when it expands, and expelling them when it contracts, and he thought that the *expansion* of the arteries is synchronous with the *dilatation* of the heart—a great error.

Now, that is the doctrine regarding the motion of the blood which continued to hamper the progress of medicine for many centuries, and undoubtedly the reason why Galen with all his ingenuity failed to correct so many errors was that he was not sufficiently impressed with the *necessity* for bringing all theories to the touchstone of *exact observation or thoughtfully planned experiment*.

The next discoverer was Michael Servetus, the Spaniard, whose tragic death at the stake—because of his religious opinions—ended untimely a life that might have rendered much service to science. In a work on "The Restoration of Christianity," published in 1553,[1] Servetus states that comparatively little blood permeates the septum of the heart; most of it passes through the pulmonary artery to the lungs, where it becomes of a crimson colour, and returns to the heart by the pulmonary veins, which carry air as well as blood. Some years later Columbo, professor of anatomy at Padua, and Cesalpinus of Pisa also described the passage of the blood through the lungs.

We now come to the discoveries of Harvey.

William Harvey, a native of Folkestone, lived at a time which will be for ever memorable in the history of England. It was the time of Shakespeare and Milton, of Dryden and Ben Jonson, of Bacon and Robert Boyle, and it is not too much to say that Shakespeare did not do more for English literature than did Harvey for English medicine. Harvey was well educated. He took the degree of Bachelor of Arts at the University of Cambridge, and as the medical schools of Italy were then more celebrated than those of England, he went to Padua, and there studied medicine for five years. He returned to England, took the medical degree of Cambridge, and settled in London. He was appointed physician to James I., and afterwards to Charles I., who took a deep interest in his experiments, and gave him for the purpose of vivisection many animals from the Royal parks. In 1615 Harvey was chosen to give lectures on anatomy at the London College of Physicians, and in his first course in the subsequent year he gave for the first time a public account of the results of an elaborate research "On the Motion of the Heart and Blood," which had culminated in his doctrine of the circulation. Harvey was then in his thirty-eighth year. He had been in no haste to catch the notice of the world by publishing fragments of his research, but he wisely waited until he had accumulated observations and arguments sufficient to establish his doctrine of the circulation upon a foundation that could not be shaken. You can at any time peruse the excellent translation of Harvey's works by Dr. Willis, and from them, together with the account of Harvey's life by the translator, learn how Harvey arrived at his results. He had at Padua been instructed in the doctrines of Galen. He had learned Columbo's account of the manner in which the blood passes from the right to the left side of the heart through the lungs; he had also learned the anatomy of the valves of the veins. These valves were discovered in 1574—whether by Fabricius or Sylvius is disputed—but, at any rate, they were discovered at least four years *before Harvey was born*. He tells us, however, that their function had been entirely misapprehended by all who had preceded him. It never occurred to them that in those veins which have valves the blood can flow only one way, and that towards the heart—the very opposite of what Galen had supposed. To that point, however, we will presently return. At the outset of his great work "On the Motion of the Heart and Blood in Animals" Harvey refers to the opinions of Galen and Columbo, and then says: "It is plain that what has heretofore been said concerning the motion and function of the heart and arteries must appear obscure, or inconsistent or even impossible, to him who carefully considers the entire subject; it will be proper to look more narrowly into the matter; to contemplate the motion of the heart and arteries, not only in man, but in all animals that have hearts; and, further, by frequent appeals to vivisection, to investigate and endeavour to find the truth."

His first concern was with the *heart* and *arteries*. He tells us that he sought "by vivisection," and not by a "study of the writings of others, to discover the motions and uses of the heart;" that he was at first greatly perplexed when he looked at the moving heart; but that by "daily diligence in vivisection" on a "variety of animals," "he thought he had obtained the truth." He describes what he saw when the chest of a living animal and the pericardium are laid open: "There is a time when the heart moves, and a time when it is motionless." The events are "more obvious in the colder animals, such as toads, frogs, serpents, fish, crabs, shrimps, snails, and shellfish. They also become more distinct in warm-blooded animals, such as the dog, if they be attentively noted, when the heart begins to flag, to move more slowly, and as it were, to die; the movements then become slower, and the pauses longer, so that it is more easy to unravel what the motions really are, and how they are performed. In the pause, as in death, the heart is soft, flaccid, exhausted, lying as it were at rest" (Harvey, *lib. cit.*, p. 21). "After the pause the auricles contract and throw the blood into the ventricles, which being filled then contract, and drive the blood into the arteries. The two motions—one of the auricles, the other of the ventricles—take place consecutively, but in such manner, that there is a kind of harmony or rhythm preserved between them" (*lib. cit.*, p. 31). Harvey, therefore, was the first to give an accurate description of the cardiac movements, and to show that the great movement of the heart is not its *dilatation*, but its *contraction*, and that the heart is not a pair of bellows like the chest, as Galen had thought.

Harvey was also the first to give a correct explanation of the pulse. He proved by experiment that the pulse in the arteries is *not synchronous with, but succeeds*, the impulse of the heart, and that the pulse is due to an expansion of the vessels by blood projected into them from the heart, and *not* to any inherent power of expanding like a pair of bellows. He divided an artery, and observed that blood flowed from its cardiac end with greatest force when the artery *expands*, and *not when it contracts*. A bellows-like action of the artery would have produced precisely the opposite effect (*lib. cit.*, pp. 134, 135). He performed other experiments on exposed arteries, and completely proved that it is the force of the heart's contraction which produces the pulse, by propelling at intervals a mass of blood into a system of vessels capable of passive expansion. Need I say how great a step was made in the progress of medicine when Harvey *experimentally demonstrated the true cause of the pulse*.

Harvey also experimentally demolished the old idea that air passes from the lungs into the pulmonary veins to be mingled with blood in the heart and distributed through the arteries to the body generally. There is something like grim humour in his repeating one of Galen's experiments to confute Galen himself on this point. Harvey says (*lib. cit.*, p. 16): "If anyone will perform Galen's experiment of dividing the trachea of a living dog, forcibly distending the lungs, and then tying the trachea securely, he will find when he has laid open the thorax abundance of air in the lungs, even to their extreme investing tunic, but none in either the pulmonary veins or left ventricle of the heart. But did the heart either attract air from the lungs, or did the lungs transmit any air to the heart, in the living dog, by so much the more ought this to be the case in the experiment just referred to." Every surgeon knows well the importance of this discovery. In many of his operations he carefully

[1] See the valuable work, "Servetus and Calvin," by R. Willis, M.D., London, 1877.

guards against the entrance of air into bloodvessels, for he knows that death would inevitably follow the entrance of even a relatively small quantity of air into the veins.

Harvey also upset the doctrine that the blood passes from the right to the left ventricle through pores in the septum of the heart. He says "no such pores can be demonstrated" (*lib. cit.*, p. 17), and "why have recourse to *invisible porosities*" ..... "when there is so *open a way*" from the right to the left side of the heart through the pulmonary artery and pulmonary veins. But he also adduces experiments. He says (*lib. cit.*, p. 135) that if you tie the pulmonary veins in a living animal, and so prevent the blood from entering the left side of the heart, death ensues; and he gives you to understand that the results are similar to those in death from asphyxia—the right side of the heart becoming engorged, the left side comparatively empty; and then he concludes that "as all these particulars have been recognised by the senses, it is manifest that the blood passes through the lungs and not through the septum" in its course from the right to the left side of the heart, and that the right ventricle is intended to drive the blood through the bloodvessels of the lungs, and through them alone.

There was another great fact overlooked by all the predecessors of Harvey which was of fundamental importance in leading him to the idea that the blood moves *in a circle*. He evidently asked himself the question, How much blood does the heart transmit from the vena cava to the arteries in a given time? He found that in the dead body the left ventricle holds upwards of two ounces of blood. Then he says (*lib. cit.*, p. 48), let us assume how much less the heart will hold when contracted than it does when dilated, and how much blood it projects into the aorta at each contraction. "Let us suppose that, as approaching the truth, the fourth or fifth, or sixth, or even but the eighth part of its charge, is thrown into the artery at each contraction. This would give either half an ounce, or three drachms, or one drachm, of blood as propelled by the heart at each pulse into the aorta, which quantity, by reason of the valves at the root of that vessel, can by no means return into the ventricle. Now, in the course of half an hour, the heart will have made more than one thousand beats, in some as many as two, three, and even four thousand. Multiplying the number of drachms propelled by the number of pulses, we shall have either one thousand half-ounces or one thousand times three drachms, or a like proportional quantity of blood, according to the amount which we assume as propelled with each stroke of the heart, sent from this organ into the artery—a larger quantity in every case than is contained in the whole body! ..... But let it be said that this does not take place in half an hour, but in an hour, or even in a day; any way, it is still manifest that more blood passes through the heart" [in that time] "than can either be supplied by the whole of the food consumed or than can be contained in the veins at the same moment. ..... In short, it could be furnished in no other way than by making a circuit and returning." And then he says: "This truth indeed presents itself obviously before us when we consider what happens in the dissection of a living animal. The great artery need not be divided, but only a small branch, to get the whole blood in the body, that *of the veins* as well as that *of the arteries*, drained away in the course of half an hour or so" (*lib. cit.*, p. 50). Observe how he proved by that experiment that *all the blood* of the *veins* flows through the heart into the arteries, and can escape by an opening made into one of them, even one of small size. These are the facts that led Harvey to believe that the blood moves in a circle, and it is to be observed that he nowhere mentions the valves of the veins as in any way assisting him towards his great conception.

(To be concluded.)

THE INSANE IN WORKHOUSES.—The number of lunatics, idiots, and persons of unsound mind, detained in workhouses in England and Wales, on Jan. 1st, 1881, was 16,811—an increase of 347 on the number so detained on the corresponding day of the previous year. Of this number, however, 4718 were inmates of the Metropolitan District Asylums at Leavesden, Caterham, and Darenth, which are in the legal position of workhouses within the meaning of the Lunacy Acts; so that 12,093 lunatics or weak-minded persons were detained in workhouses proper.

NOTE ON THE CURABILITY OF TABES DORSALIS.

BY E. LONG FOX, M.D.

IN the present state of medical knowledge the words "always" and "never" should seldom be used. So many things are possible; so many exceptional cases occur in all departments of medicine; so rapid is the progress of the differentiation of disease, that what is accepted as true to-day may to-morrow admit of a different interpretation. What is cure? It is the cessation of all morbid phenomena, plus the return to a normal condition of the organ or organs affected. In many cases we conclude that the latter has occurred because the morbid symptoms have vanished. But in certain affections of the nervous system this connexion between relief of symptoms and cure of lesion does not hold good. This is the case in some states of the brain. It is notably so of the spinal cord.

Dr. Friedrich Schultze (*Arch. für Psychiatrie*, Band 12) has lately recorded a case that bears on this point. In brief it was as follows: A man, aged forty-three, previously healthy, came under observation in April, 1871, but had suffered lancinating pains in the lower limbs for two or three years. For one year there had been unsteadiness of gait, commencing vesical phenomena, and feeling of numbness in the left ulnar nerve. These symptoms increased more and more. Unsteadiness of gait, especially in the dark, was worse. There was nocturnal enuresis, and by day it was difficult for him to retain his urine. Under the use of nitrate of silver his condition had been better of late; he did not sway so much when the eyes were closed, and the irregular movements of the legs were almost gone. He was placed under galvanic treatment. In a fortnight there was improvement of gait, and hardly any sensory abnormality, except numbness of the left ulnar in the fourth and fifth fingers, diminution of sexual desire, nocturnal enuresis. By the middle of May the enuresis had vanished. He could go up a mountain without great fatigue; the lightning pains quite gone. Vesical weakness present, but slight. Left ulnar numbness persisted.—February, 1872: Improvement continues; no pains; much less ulnar numbness. Feeling of fatigue in lower extremities still abnormally great; fatigue even after one hour's walk. Galvanic treatment resumed. In 1873 no pains; hardly a trace of ulnar numbness. No ataxic gait. Occasional nocturnal enuresis and dropping of urine. So to the end of June, 1880, about twelve years from the beginning of the phenomena. At this time gait was normal. No ptosis; no sensory abnormalities. Complete loss of patellar tendon-reflex on both sides; slight vesical paralysis, with nocturnal enuresis and dripping of urine by day; catarrh of bladder; urine not alkaline. Pupils act weakly to light. The galvanism had no effect on the bladder symptoms. No spinal fatigue after an hour's walk. The patient died suddenly from accidentally swallowing some corrosive substance.

Post-mortem examination.—Spinal cord abnormally thin and pale; spinal dura mater and pia mater normal; anterior portion of cerebral pia mater thickened; no granulation of ependyma. After preparation of spinal cord the volume of the cord small in dorsal and lumbar regions; less so in cervical; great degeneration of posterior columns, only the sections bordering on the posterior commissure were rich in nerves. In the middle part of the lumbar bulb the parts of the posterior columns lying directly on the posterior horns were somewhat rich in nerves. In the dorsal region nerve fibres were found in the parts bordering the anterior third of the posterior horns. In the cervical region Goll's columns were free, but the border between the fasciculi graciles and the fasciculi cuneati was marked by a small zone of degeneration. In the upper two-thirds of the cervical bulb there was a complete triangle of degeneration, the base of which lay on the cuneiform columns of the periphery, and the apex in the small zone above mentioned. In the cervical bulb the region of the inner root bundle was degenerated, and most on the left side. In the medulla oblongata the degeneration extended to the boundary zone between the posterior column bundle and Goll's columns, decreasing in extent and intensity; the lateral columns and grey substance normal. In carmine preparations atrophy of nerve fibres, and increase

of connective tissues were seen; no granular cells; a few corpora amylacea; anterior horn cells intact.

Dr. Schultze refers to several interesting points in this case. The small volume of the whole cord, which he thinks may be a congenital condition in cases of hereditary ataxy; the recovery from ataxic symptoms whilst the lesion of the lateral parts of the cuneati in almost the whole extent of the cord remained; the paræsthesia of the left ulnar region in connexion with the severe affection of the left cuneated columns in the cervical bulb; the moderate amount of degeneration of the posterior columns in the lumbar bulb, apparently leading to no sensory phenomena in the lower limbs; but the important feature was that the initial symptoms were all recovered from for years, except the bladder weakness and the absence of the patellar reflex, in spite of persistent grave anatomical lesions, and he asks: "Does this show that the anatomical lesion exists even in the earliest stages of tabes, when the symptoms are few, and that the view that a symptom stage precedes that of true anatomical destruction is untenable." At any rate a case like this suggests to us that no instance of so-called cure of tabes should be considered as such unless, death having resulted from some cause alien to the tabes itself, the posterior portions of the cord are found healthy. In a case in which the ataxic symptoms were peculiarly prominent, the patient not being able to guide his legs at all, even with the help of sight, and with the support of an arm on each side, under the long-continued use of ergot the gait became normal, and he left the hospital able to walk straight and in a perfectly coördinate manner with closed eyes. The patient went out thinking himself cured, and returned in about a year paraplegic, and after some months died. Apart from the extension of the lesion into more anterior regions of the cord, the posterior root zones were found sclerosed in an extreme degree, and it was quite evident that during the remission of the symptoms the lesion of the cord had not improved at all.

In this case the duration of the disease was from seven to eight years, and the temporary improvement took place after four years' ailment, so that it does not directly bear upon the question of the curability of tabes in a pre-ataxic stage. But it is an instance of very complete remission of some of the gravest phenomena, with persistence of the lesion. There is no doubt that greater confidence would be felt in the curability of tabes if it were proved that this lesion is as closely connected with syphilis as some observers state. Erb considers that about 85 per cent. of such cases are specific, and Dr. Dowse, in a recent excellent paper, goes even farther when he says: "I feel sure that nearly every case of locomotor ataxy is due to syphilis, either hereditary or acquired; so much so, in fact, that it may well be called syphilitic ataxy." It is certain that a large proportion of cases of locomotor ataxy have had syphilis at some period of their life. It seems less certain that the syphilis has had much to do with the lesion, at least directly. Indirectly the subjects of previous syphilis may be more liable than others to any disorganising process; but pathological evidence shows that syphilis affects the spinal centres with a different arrangement from that which obtains in tabes, and clinical experience proves that but few such cases derive much benefit from mercurials and iodide of potassium.

The old question therefore crops up again, "Can syphilis by its *toxic* influence on the nervous centre induce the various phenomena that are called the pre-ataxic signs of locomotor ataxy, without sclerosis of the posterior root zones?" If this can be proved, it seems only reasonable to believe that at this stage the mischief may be checked by treatment. But take the following case: A weakly man, of forty-four years of age, finds his walking powers, which had been very good, gradually diminish for some twelve months. He contracted syphilis in a severe form, and within ten days of the first appearance of the sore he suffered from decided paresis of the lower limbs. Within three weeks he became almost paraplegic as regards motion and sensation, with partial retention of urine. Patellar tendon-reflex absent; diplopia from slight paralysis of the right external rectus. No retinal lesion; pupils acted to light, though sluggishly. Ulnar numbness in each hand; sense of hearing confused. He was placed under antisyphilitic treatment, with the effect of making every symptom worse, and materially injuring the general health. Under a long course of phosphorus and strychnine with cod-liver oil the ulnar numbness diminished, sensation returned in the lower limbs; the power of walking was regained to a considerable extent, although a stick was necessary to enable the patient to walk quite straight. All the bladder symptoms vanished, and the diplopia was only observable at times in the day, when there had been much fatigue.

Is this recovery? No. The patellar tendon-reflex is still absent. Is the disease syphilitic? If so, why did not the appropriate treatment do good instead of harm, especially as in this case, if ever, the important symptoms would seem to have depended on syphilitic poisoning. Have we however, as yet, any proof that sclerosis can be recovered from? The remission of symptoms, even for several years, leads to the belief that under treatment directed to the tone of the vessels, or the nutrition of the cord, other tracts of this organ take on the duties that we consider the attributes of the posterior root zones. But during this very remission, if we may judge by pathological anatomy, the lesion is slowly, though surely, following a progressive course; and, although there is nothing impossible in the more hopeful view of cure, I would still repeat that so far published facts are wanting to prove it, whilst, on the other hand, many cases of temporary improvement of symptoms have shown eventually post mortem a steady progress of the lesion.

Clifton.

ON THE

TREATMENT OF PSEUDO-MEMBRANOUS (DIPHTHERITIC) CONJUNCTIVITIS BY LOCAL APPLICATIONS OF SOLUTION OF SULPHATE OF QUININE.

By JOHN TWEEDY, F.R.C.S.,

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TWO years ago I recorded several cases of true diphtheritic ophthalmia that had been successfully treated, so far as concerned the integrity of the cornea, by local applications of sulphate of quinine (THE LANCET, 1880, vol. i., pp. 125, 282). Since then I have similarly treated four other cases, and though the cornea remained wholly intact in only one of these, they all recovered with useful sight, and with, at worst, but slight nebulæ. To the quinine I ascribe the credit of saving the cornea in these cases from total destruction. Three of the four cases occurred in men and one in a woman. Two began as purulent conjunctivitis of gonorrhœal origin, and two were pseudo-membranous from the first. The former, a man and a woman, were admitted with advanced purulent conjunctivitis of the right eye, the left being free. In both instances, within a few days of admission, and while the inflammation of the right conjunctiva was subsiding, the *left*, in spite of protection by Buller's shield, became the seat of adherent pseudo-membranes. In neither did much pseudo-membrane appear on the right conjunctiva. As regards the two cases that were primarily pseudo-membranous, it is noteworthy that both occurred in men engaged in handling animal carcasses, one being a porter in Smithfield meat-market, the other a slaughterman in the country. No direct contagion from pharyngeal diphtheria or other similar disease could be traced in either of the cases. The meat-carrier thought he had acquired his disease from contact with an acrid "sweat" on some diseased American pork he had been carrying. The slaughterman did not connect his illness with his occupation, though he volunteered the statement that he had often killed diseased animals, and that but few calves have perfectly healthy livers, "not one in ten," most of them containing larger or smaller collections of putrid "matter."

I need not relate the details of the cases; they were all treated in the wards of the Royal London Ophthalmic Hospital.

As soon as the nature of the disease was definitely recognised, all other treatment, if any, was stopped, and quinine lotion, containing four grains of sulphate of quinine, with a minimum of dilute sulphuric acid to an ounce of water, was alone employed. As far as possible the diseased surfaces were kept constantly bathed with the

solution, the conjunctival sac being converted, as it were, into a trough holding the quinine lotion. A bowl of the solution was also placed within reach of the patient, who washed the eye frequently and kept a well-soaked compress constantly applied in the intervals. Besides these applications by the patient and by the nurse, the house-surgeon visited each case three or four times a day. On these occasions the lids were everted and the conjunctival sac thoroughly cleansed with the quinine lotion. The superficial disintegrated portions of the exudations were then gently removed with wet lint, care being taken not to aggravate the inflammation by rough handling or by rude attempts to tear off the pseudo-membrane. Usually, the quinine lotion was iced. In two cases the local application of powdered sulphate of quinine was tried at first, or sulphate of quinine rubbed up with an equal part of calomel; but, in addition to causing great pain, the powder did not appear to be so beneficial as the quinine in solution, and was therefore soon abandoned.

The virtues of the quinine are, I believe, specific in the diphtheritic exudation, and manifest themselves by checking or controlling the inflammatory process and the limiting the inflammatory neoplasms. Whatever may be the influence of the minute organisms that are said by some writers to be essential factors in producing diphtheria, it is certain that in diphtheritic ophthalmia the cornea is destroyed by the degree of the inflammation and the amount of concurrent exudation. The bacteria or vibrios or micrococci (for there is a hopeless disagreement as to which are the noxious organisms) do not destroy the cornea; nor, on the other hand, do strong applications of carbolic acid, which is, we are told, so fatal to "germs," arrest the progress of the pernicious pseudo-membrane in time to save the cornea. Three of the cases to which I have referred were at first treated by frequent ablutions with a five per cent. solution of carbolic acid, and in every instance the pseudo-membranes rapidly spread under these applications, whereas they were immediately controlled by the quinine lotion. Personally, I have a strong impression that the carbolic acid did harm, by aggravating the inflammatory process, and thereby increasing the amount of exudation. But, as formerly remarked, quinine not only checks the inflammation, but it is likewise detergent and antiseptic. (See THE LANCET, 1880, vol. i., p. 282 *et seq.*)

In my previous communications I stated briefly the reasons that led me to employ quinine in cases of true diphtheritic ophthalmia. With these reasons I am still content. Indeed I would now even emphasise them, as I would also emphasise the fundamental difference between the pellicular membrane of ordinary purulent ophthalmia and the parenchymatous pseudo-membrane of diphtheritic conjunctivitis. Extended experience has satisfied me that the two forms are essentially distinct and separate in their pathological as well as in their clinical relations. The pellicular form is amenable to simple treatment, and need not give much anxiety, whereas the pseudo-membranous is terrible in its ravages and appalling in its possibilities. Not a little harm may be done by confounding these two diseases. An application of nitrate of silver to the pseudo-membranes of diphtheritic ophthalmia increases the damage, whereas judicious applications speedily cure the membranous variety of purulent ophthalmia. The difference is appreciable from the earliest to the latest stages. Even when the pseudo-membrane is thin and detachable, its removal does not expose a swollen and vascular mucosa, but a smooth, pale surface often of a dull leaden hue. Later on the difference is still more marked; the membranous form only affects the epithelial layers of the mucous membrane, whereas the pseudo-membranes always invade the deeper texture, and heal by cicatrisation. In all the cases I have diagnosed as diphtheritic conjunctivitis cicatrisation was always pronounced.

It has by some been objected that the term *diphtheritic* conjunctivitis is a misnomer because the disease is not usually attended by grave constitutional symptoms, and because the pseudo-membranes do not spread to other parts. To these criticisms I would answer, first, that even pharyngeal diphtheria is often unattended by much constitutional disturbance; and, second, that the conditions of the conjunctival mucous membrane are little favourable to the extension of the disease down the nasal duct. There are many reasons for believing that diphtheria is primarily a local disease, and that the constitutional infection occurs secondarily. The poisoning in pharyngeal diphtheria is due partly to the inspiration of the noxious gases generated in the putrefying pseudo-membrane, and partly to the ingestion of the detritus from these decayed masses. In the case of diphtheritic ophthalmia, on the contrary, the disease is shut out from the system by the conjunctiva and underlying tissues, and all the discharge escapes externally, so that the risks of constitutional infection are few, though not altogether absent. Of the nine cases that I have recognised as genuine diphtheritic conjunctivitis two (infants) died within three weeks, one of what was called "inflammation of the lungs," the other of pharyngeal diphtheria. Five had more or less extensive adherent pseudo-membranes inside the mouth or in the pharynx; and most of the patients showed extreme, almost characteristic, pallor, accompanied with general malaise. As regards the extension of the pseudo-membranes from the conjunctiva down the nasal duct, it may be said that if the diphtheritic pseudo-membrane rarely spreads from the nasal cavity up the nasal duct into the conjunctival sac, it is not surprising that it should so seldom travel in the opposite direction. The canaliculi and the nasal ducts may roughly be compared to funnels with the mouths downwards; hence it is easier for inflammation to extend from the nasal cavity to the conjunctiva than from the conjunctiva to the nose. The canaliculi are normally too small to allow the pseudo-membrane to pass through them, and very little swelling of the mucous membrane would obliterate them altogether. It does, nevertheless, sometimes happen, as I have just hinted, that even when the diphtheritic process begins in the eye it shows itself subsequently in other parts. This actually occurred in the meat-carrier referred to above. Four days after his admission into the hospital, and after the conjunctival mucous membranes showed appreciable improvement, he complained of soreness of the throat. Within twenty-four hours his tongue, roof of the mouth, and inside of the cheeks and lips were covered with an adherent dirty coating, which could not be rubbed or pulled off. The pharyngeal mucous membrane was red and swollen, and soon became completely covered with a thick pseudo-membrane, exactly resembling that on the conjunctiva. He eventually made a good recovery, and left the hospital with perfectly clear corneæ, though his palpebral conjunctivæ were contracted by dense cicatrices. Furthermore, it should be borne in mind that the pseudo-membrane of diphtheria usually spreads more quickly by contiguity of tissue than by continuity. This is especially noticeable in pharyngeal diphtheritis where, say, one tonsil becomes affected, then the contiguous portion of the uvula, and then the intervening arch.[1] So in the conjunctiva two opposing portions of ocular and palpebral conjunctiva become affected long before the pseudo-membrane has time to travel round by the oculo-palpebral fold.

One word of explanation may be necessary—namely, that all four cases were of a very severe type. In one case (gonorrhœal) the conjunctival sac looked as if it had been filled with dirty tallow, except opposite the cornea, which was of a turbid sea-green colour. In the case where the pseudo-membrane was least in amount and extent (the slaughterman) the cornea suffered most. After the pseudo-membrane had disappeared a superficial ulceration spread over the greater part of the cornea, but did not cause much opacity.

I must, in conclusion, thank Mr. Burnham, Dr. Webster Fox, Mr. Milles, and Dr. Fitzgerald, past and present house-surgeons, for the intelligent and sympathetic manner in which they carried out my instructions and conducted the various observations.

[1] For a detailed description of the mode of extension of the diphtheritic pseudo-membrane in the pharynx, see Trousseau's Clinique Médicale, 5th edition, vol. i., p. 423; or the New Sydenham Society's Translation, vol. ii., p. 472.

REWARDS FOR MEDICAL MEN IN CHINA.—The following paragraph appeared in the *Daily News* on the 4th inst.: "The late Empress of China having recovered from her former serious illness, some half-dozen surgeons, chosen by governors of provinces and sent to Pekin, according to Imperial instructions, to attend upon her Majesty, have been rewarded by various appointments. One, it is announced, is to be made a taotai, or intendant of circuit, another a prefect, another a district magistrate, and so forth. 'This,' says the *Shanghai Courier*, 'is very much as if after the recovery of the Prince of Wales from his historic illness Sir William Jenner had been made a county court judge and Sir W. Gull a stipendiary magistrate.'"

ON TWO CASES OF

ACUTE MYELITIS ASSOCIATED WITH OPTIC NEURITIS.

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WHILST optic neuritis is found to accompany many, and the most varied, forms of brain disease its occurrence in spinal diseases must be considered to be of great rarity. Leaving out of consideration the simple atrophy of the optic disc so often found in locomotor ataxy, and occasionally also present in disseminated sclerosis, in lateral sclerosis, and in the combined posterior and lateral sclerosis, in all of which the atrophy of the optic disc is simply of degenerative nature and not preceded by neuritis, there are but few cases on record in which optic neuritis has been found complicating acute spinal diseases.

In cases of injuries to the spine Clifford Allbutt[1] describes ocular changes, especially when the injury occurs high up in the cord, consisting of simple congestion, congestion with œdema, and slight neuritis, uniform redness of the disc, and concealment of the outline. Mooren[2] also seems to have observed some cases of spinal concussion followed by optic neuritis, and a well-established case is reported by Thorowgood,[3] where a blow on the lower part of the back, which produced pain and tenderness in the neck, was followed a few weeks after the injury by well-marked optic neuritis.

In caries of the spine in the cervical region congestion of the disc has been described,[4] but here again it is very rare. Abadie records one case[5] in which optic atrophy supervened. Gowers describes another in which, however, the pathological nature of the appearance was somewhat doubtful. In cases of myelitis the record of ocular changes is equally meagre. Clifford Allbutt[6] describes one case of partial atrophy of the discs coming on after myelitis of the dorsal cord. Erb[7] describes a case of transverse dorsal myelitis with marked optic neuritis going on to atrophy, which, in the course of some months, completely recovered. Seguin[8] gives two cases of subacute transverse myelitis, combined with optic neuritis. In the first of these two cases there was temporary retention of urine, marked anæsthesia of the lower extremities, but no paralytic symptoms, and normal patellar reflexes. The diagnosis of this case seems, therefore, somewhat doubtful. In the second case, the lower extremities were anæsthetic, and for a time paraplegic. Both cases completely recovered under iodide of potassium, with the application of galvanism and the massage in the second. In view of our scanty knowledge on this subject, a brief account of two cases of acute spinal myelitis, associated with optic neuritis, going on to complete atrophy in the one case, may be of interest, especially as in both the diagnosis was confirmed by post-mortem examinations, and in one of them a careful microscopic examination of the optic nerve, the spinal cord, and some portions of the brain was made.

CASE 1. *Paraplegia of lower extremities; paresis of upper extremities; no anæsthesia; optic neuritis; death. Transverse myelitis of cord in the cervical region; congestion of the brain and its membranes.*—Sarah G——, married, aged thirty-eight, was admitted into the Manchester Infirmary on February 9th, 1874. The patient, a factory operative, had always enjoyed good health till three weeks before admission, when, after exposure to cold, she complained of numbness and weakness in her legs; she went to her work, had a fall and was unable to raise herself ever afterwards. She complained of an occasional pain in her head, but had never vomited except once, two days after her fall, and had never had any convulsions. On admission the patient was found to be a healthy-looking, fairly nourished person. The lower extremities were completely paralysed; the sensation in them, however, was normal to touch, to pain, and to temperature. The reflex irritability increased. There was no atrophy, and the reaction to both the galvanic and faradaic current was normal. The upper extremities were paretic, the grasp was weak, but the patient was able to feed herself and perform other movements requiring no great power. The sensibility in the upper extremities was normal; neither was there any atrophy or change in the electric reaction. The bowels were constipated the urine (which had to be drawn off by a catheter) was alkaline in reaction, but contained neither albumen nor sugar. The patient complained of pain in the back of the neck, which, however, was not increased by pressure on that part. There was nothing abnormal to be noticed on inspecting the spinal column; percussion of the spine caused pain both in the cervical and dorsal regions. The patient complained of transient pain in her head, the cerebral nerves were normal except the optic nerve. Mr. Windsor, then ophthalmic surgeon to the Manchester Infirmary, examined the eyes and found marked optic neuritis, the disc in each eye being swollen to the extent of one millimetre. The vision, however, was good. The patient seemed somewhat slow in answering questions, her intelligence, however, was good, and she showed no mental disturbance. An examination of the internal organs showed nothing abnormal except the retention of urine already noticed. The appetite was bad, tongue slightly furred. Temperature 97·6°, respiration 18 per minute, pulse 80. During her stay in the hospital the condition of the patient varied for a time but little, with the exception of a gradually increasing weakness in the upper extremities and the formation of bedsores. The temperature varied, but was never much above the normal. Towards the end of February the patient became much weaker, she began to suffer from cough, the respiration became much quicker, there was paralysis of the diaphragm, and on March 1st she had slight convulsion and died.

The post-mortem examination was made about twenty hours after death by Mr. Thomas Jones, then pathological registrar. The chest and abdominal organs showed no noteworthy changes, except excessive hyperæmia and lobular pneumonia in both lungs. On opening the head the membranes of the brain were found very much congested; the brain substance showed many bloody points, and the lateral ventricles contained more than the ordinary amount of serum. Before removing the brain a ligature was put round each optic nerve in front of the commissure, and the nerve cut through behind the ligature and the brain then taken out. On now making a section through the optic nerve still attached to the eye a large drop of serum immediately collected at the cut end of the nerve, showing the serous effusion within the sheath of the nerve. On removing the spinal cord the vessels of the membranes were found to be engorged with blood. The spinal cord was found to be healthy, except in the region of the cervical enlargement, where to the extent of about one inch and a half, involving the greater part of the enlargement, the cord was exceedingly soft and yellowish. The affection extended transversely through the whole thickness of the cord. The cord was reserved for microscopic examination; owing to pressure of work such examination could not be made at the time, and the cord, unfortunately, became lost afterwards.

(To be concluded.)

1 Gowers, Ophthalmoscopy, p. 155.
2 E. Pflüger in Arch. f. Ophthalm., xxiv., p. 169, 1878.
3 Clin. Trans., viii., p. 80, 1875.
4 Gowers, Ophthalm., p. 154.
5 Bull. de la Soc. de Chir., Jan. 12th, 1876.
6 Gowers, loc. cit., p. 149.
7 Arch. f. Psychatr., vol. x., p. 146, 1879.
8 Journ. of Nerve and Mental Diseases. April, 1880. Abstract in Schmidt's Jahrb., vol. clxxxix., p. 31, 1881.

A CASE OF TRAUMATIC ANEURISM OF THE POPLITEAL ARTERY, WITH SUCCESSFUL LIGATURE OF THE VESSEL.

BY JEREMIAH M'CARTHY, F.R.C.S. ENG.,
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ON October 5th I was called to see, in consultation with Mr. F. M. Corner, of Poplar, a case of accidental wound of the popliteal artery, in a child aged four years. The accident had happened ten days previously. The child, who did not yet wear trousers, was carrying a bottle of soda-water, and let it fall upon the ground, when the bottle exploded, and a fragment struck him in the right popliteal region, inflicting a wound, from which there was profuse bleeding. This was temporarily arrested by the child's friends, and Mr. Corner was sent for. As he was engaged elsewhere, his assistant, Mr. Vernon, went to the case, and,

as there was now only some venous oozing from the wound, he applied a compress and bandage, by which all hæmorrhage was arrested. The child was, however, nearly pulseless. On the fourth day the bandage was changed, but, as there was no bleeding and no reason for removing the compress, this was not disturbed. On the tenth day the wound was healed, but a pulsating tumour about the size of a filbert had formed. Another compress and bandage were applied, but during the ensuing night the child became very excited and kicked about, causing a reopening of the wound and renewal of the bleeding.

I was now called in consultation, and found the child very anæmic, with some œdema of the right leg and foot. There was a wound a little above the bend of the right knee, from which the blood was oozing, and a pulsating tumour occupying the upper three-fourths of the popliteal region. It was evident that the popliteal artery or some large branch of it had been wounded. The child having been anæsthetised by Mr. Corner, I made a vertical incision for about three inches through the skin and fascia, and then removed a considerable quantity of tough, firmly adherent clot. The popliteal artery now became visible, at the bottom of the wound for about two inches in length, partly overlapped by the internal popliteal nerve. There was no trace of the popliteal vein, which had probably been completely divided at the time of the accident. When the nerve had been drawn to the inner side the wound in the artery could be seen on the posterior wall of the vessel, circular in shape, about one-eighth of an inch in diameter, and filled with clot. The surface of the vessel for about three-quarters of an inch below this was riddled with small holes, from which, even while the tourniquet was applied, some blood-stained fluid exuded. Two catgut ligatures were applied, so as to include between them about an inch of the artery. On the removal of the tourniquet there was still some fresh bleeding from the lower part of the wound. I therefore divided the vessel between the ligatures, dissected up the distal end, and again ligatured it about half an inch lower down. There being no more hæmorrhage, the wound was closed with carbolised silk sutures, and was dressed antiseptically. A back splint was applied to keep the limb at rest. For a week the wound remained aseptic, but showed little disposition to heal. The subsequent history of the case has been kindly sent to me by Mr. Corner:—"The wound did not continue aseptic, nor did any part heal by first intention; and when it was nearly healed a collection of pus was found high up on the front of the leg, which, on being opened, let out a lot of pus and a piece of muscle with a short tendinous attachment, the whole about an inch long. Now (Dec. 6th) the wounds, front and back, have been healed for several weeks."

I did not understand at the time of the operation how the smaller holes in the wall of the artery could have been produced. A possible explanation may be that vascular communications had formed between the vasa vasorum and the organising clot, and that these, necessarily torn across in the removal of the adherent clot, did not contract in consequence of the previous application of an Esmarch's bandage, which seems to produce temporary paralysis of the walls of the smaller vessels. The abscess and sloughing of muscle on the front of the leg were probably due to the breaking down of a thrombus.

The operation was done under carbolic spray, and presented no difficulty, owing to the able assistance of Messrs. Corner and Vernon.

LONGEVITY IN IRELAND.—In the quarter ending the 30th of September last the deaths of eleven persons in Ireland were registered whose ages were stated to be 100 years or upwards. Of these aged persons seven were women. Their respective ages were as follows:—One 100 years; one 101; two 103; one 104; one 106; and one 115. The first, one of the third, and the two last-mentioned deaths occurred in the Donaghmore, Forkill, and Meigh districts, Newry union. Three died at 100 years; six not mentioned; and one man, who died in the Killaun district, Enniscorthy union, at 101, was, the registrar states, able to work on his farm up to within a week of his death. In reference to two of the women who died at 100 and 103 respectively, the registrar observes of the former that she was able to go about the day before her death; her senses were perfect up to the last; and of the latter, the last eighty years of her life were spent in a cabin on the summit of the highest of the Burrow mountains.

SALICYLATE OF SODA IN ACUTE AND SUBACUTE RHEUMATISM.[1]

BY SIDNEY COUPLAND, M.D., F.R.C.P.,
PHYSICIAN TO THE MIDDLESEX HOSPITAL.

MY contribution to this subject consists in an analysis of eighty-four cases of acute and subacute rheumatism treated with more or less rigour by salicylate of soda. Statistics from the Middlesex Hospital bearing on this subject have been published by Dr. Finlay and Mr. Lucas in 1879,[2] and by Dr. Greenhow in 1880.[3] I decided to limit my survey to the cases which have occurred in my own wards during the two years I have been physician, in the hope that a closer scrutiny might thus be possible, than if one were dealing with a larger body of cases, and thus something more than a statistical inquiry be attempted. I may remark, however, that the number of cases exceeds that analysed by Dr. Greenhow, and as they came from the same hospital the two series may well be compared. But I have not, like Dr. Greenhow, excluded the mild cases, and with nine exceptions[4] the administration of the salicylate was commenced upon the day of admission. In a few cases it was entirely abandoned from intolerance on the patient's part or apparent inefficacy on the part of the drug.

I should also state that the doses which were administered were by no means heroic, the endeavour being to give as small an amount as possible consistent with the production of relief from pain and fever, for it had seemed that large and frequently repeated doses, rapidly efficacious though they are, have to be soon abandoned owing to the inconvenient, if not serious, toxic effects they produce. Only once, then, has as much as 160 grs. in the twenty-four hours been given, or 20 grs. every three hours—not often 120 grs., more frequently 90 grs. (or 15 grs. every four hours), and 60 grs. (or 15 grs. every six hours). Dr. Maclagan remarked at the last meeting that the rapid elimination of the drug required its frequent renewal and administration in large doses; but although I have several notes of the rapid appearance of the salicyl reaction in the urine, as tested by the perchloride of iron, I have also notes where the reaction has been obtained two or three days after discontinuance of the drug, and Dr. Fagge quoted a case of Dr. Habershon's in the same sense. Moreover, the toxic effects are seldom produced after the first dose, but after two or three doses have allowed the drug to act with cumulative effect. I should argue, then, that the drug continues to exert an effect for some time after its administration has been discontinued. The point, however, is one which will be raised again in speaking of relapses. I may simply add now that throughout the principle has been recognised to prevent relapse, if possible, by continuing the administration long after the subsidence of the primary fever and articular manifestations; and frequently the dose has been gradually reduced in the hope that the patient may be kept to a slight extent at least under its influence.

With these preliminaries I may proceed to deal with the series of cases treated by salicylate of soda. I have said they were 84 in number; and the course of each case, especially with reference to the salicylate, is shown graphically in the accompanying chart. (This chart[5] contained 86 cases; 4 of them—Nos. 6 to 9—were treated partly by salicin and partly by other methods; they were therefore excluded from the analytical summary. Of the remaining 82 two were re-admitted, and were reckoned, for the sake of convenience, as new cases, thereby bringing the total to 84.)

GENERAL ANALYSIS.

Sex.—Of these 82 cases, 41 were males and 41 females.

Age.—There were under 10 years ... ... 2 cases.
10 and " 20 " ... ... 25 "
20 and " 30 " ... ... 46 "
30 and " 40 " ... ... 5 "
40 and " 50 " ... ... 3 "
" 60 " ... ... 1 "

(Nos. 10A and 31A, readmitted, not included.)

[1] Read before the Medical Society of London on Dec. 19th, 1881.
[2] THE LANCET, 1879, vol. ii., p. 429. [3] Clin. Soc. Trans., xiii., p. 262.
[4] In 2 on the second day, in 4 on the fourth, and in 1 case each on the seventh, ninth, and tenth days respectively. [5] Not published.

Number of Attacks.—The number of the attack of rheumatism from which the patient suffered was—

1st attack	... ...	38 cases.
2nd ,,	... ...	24 ,,
3rd ,,	... ...	13 ,,
4th ,,	... ...	3 ,,
5th ,,	... ...	4 ,,
		82

Date of admission.—There were admitted on the—

2nd day of declared symptoms	...	2 cases.
3rd ,, ,, ,,	...	14 ,,
4th ,, ,, ,,	...	8 ,,
5th ,, ,, ,,	...	5 ,,
6th ,, ,, ,,	...	13 ,,
7th ,, ,, ,,	...	10 ,,
8th ,, ,, ,,	...	11 ,,
9th ,, ,, ,,	...	1 ,,
10th ,, ,, ,,	...	3 ,,
12th ,, ,, ,,	...	1 ,,
14th ,, ,, ,,	...	8 ,,
17th ,, ,, ,,	...	1 ,,
In 3rd week ,, ,,	...	1 ,,
,, 4th ,, ,, ,,	...	3 ,,
,, 5th ,, ,, ,,	...	1 ,,
2nd month ,, ,,	...	2 ,,

Severity of Attack.—As the terms "acute" and "subacute" are too vaguely separated to be of much use as a means of classification, and yet, as it seems to be important to have some means of ascertaining whether the drug acts as well in mild as in severe cases, the series has been divided into six classes, according to the maximum temperature attained within the first twenty-four hours after admission, excluding the earliest record as being liable to be influenced by removal to hospital.

The classification results as follows:—

Above . .	104°	Class I.	5 cases
104° and above	103°	,, II.	9 ,,
103° ,,	102°	,, III.	15 ,,
102° ,,	101°	,, IV.	23 ,,
101° ,,	100°	,, V.	21 ,,
100° ,,	98·4°	,, VI.	11 ,,

All of these cases are complete, with the exception of one (No. 84) still in hospital. One case died.

SPECIAL ANALYSIS, WITH REFERENCE TO TREATMENT.

These cases will be analysed under the following heads:

1. Duration of pyrexia.
2. Duration of joint affection, as indicated by pain.
3. Relapses (*a*, of pyrexia; *b*, of joint affection), as to their time of occurrence, duration, and relation to the drug.
4. Duration of stay in hospital.
5. Total duration, from commencement of symptoms to date of discharge.
6. Frequency of pericarditis, endocardial murmurs, and their relation to treatment.
7. Other complications.
8. The toxic effects of the drug, or "salicylism."

1. *Duration of pyrexia.*—As there is not by any means an invariable connexion between the subsidence of the pyrexia and the disappearance of joint pain, even in cases uncomplicated by pericarditis or visceral inflammations, I have thought it well—following, indeed, Dr. Warner's example—to separate these two main features of rheumatic fever, in the hope, also, that one may be able to show whether the drug has more influence over the pyrexia than over the articular manifestation, or the reverse. Speaking generally, I can quite corroborate the statements made as to the very striking amelioration produced by the drug in the severity of the joint affection; but, also, as a general rule, it will, I think, be found that its influence over the pyrexia is even more striking, and that the pains in joints persist for a shorter or longer period after the temperature has become normal.

There are two cases in this series that stand apart. One is No. 84, still under treatment, and for seventeen days rebellious to salicylate of soda, given for ten days in doses of 160 grains, so that it was discontinued, and has only lately (thirtieth day) been represcribed. In her neither pyrexia nor articular inflammation has subsided for upwards of four weeks. The other is No. 25, which, being quite peculiar, has been excluded from these statistics. In that case the joint affection was mild but variable, eventually becoming chronic, and accompanied by much muscular wasting. The temperature, however, attained great height, particularly during the first four weeks after admission, calling for treatment by cold baths. The hyperpyrexia was genuine, the skin being burning hot, and its recurrence regular every afternoon, but the patient did not exhibit the usual nervous symptoms of cerebral rheumatism, and her life never seemed to be endangered. She remained in the hospital 154 days. To include such a case in the statistics of only eighty-four cases would materially modify the conclusions, and I therefore propose to omit it statistically, but to include it, as well as two other of the more interesting cases, in an appendix to this paper.[6] I need only remark that the high temperatures were developed whilst she was taking the salicylate, which was discontinued when shown to have no appreciable influence upon the pyrexia.

TABLE A.—*Showing the Days on which the Primary Pyrexia and Joint Pains Subsided, the Day of Discharge from Hospital, and the Number of Relapses, in connexion with the Severity of the Attack (Maximum Temperature).*

	No of case.	Day of subsidence of pyrexia.	Day of subsidence of joint pains.	Day of discharge.	Relapses. P.	Relapses. J.
Cl. I.—Ab. 104°.	1	11	13	38	0	0
	25	—	—	154	0	0
	70	3	5	28	0	0
	72	3	7	55	2	1
	81	5	10	82	3	3
Cl. II.—Ab. 103°—104°.	12	9	3	43	1	0
	16	19	9	61	0	0
	26	5	8	15	0	0
	32	4	7	28	0	0
	60 (*b*)	8	8	38	0	0
	64	4	4	21	0	0
	71	10	7	41	1	1
	83	4	4	17	0	0
	84	—	—	—	0	0
Class III.—Above 102°—103°.	3	5	4	57	0	1
	4 (*a*)	19	5	20	0	0
	10	3	5	40	0	0
	10A	5	7	34	0	0
	11 (*c*)	23	8	52	0	0
	18 (*d*)	11	11	59	2	2
	28	5	8	95	4	3
	31A	4	5	38	1	1
	33	24	25	81	1	1
	35	4	7	28	0	0
	43	6	10	28	0	0
	52	4	6	55	0	0
	76	19	19	38	1	1
	79	15	16	17	0	0
	80 (*a*)	5	6	17	0	0
Class IV.—101°—102°.	5	3	5	27	0	2
	14	3	8	42	3	2
	17	4	4	44	1	3
	19	29	3	77	0	0
	21	25	23	49	0	0
	22	5	6	37	1	1
	23	14	19	33	0	0
	24	3	5	33	0	0
	38	5	8	34	0	0
	42	2	7	36	1	0
	44 (*b*)	15	16	42	0	0
	47	2	7	64	2	2
	50	2	10	28	0	0
	51	6	16	55	1	1
	58	5	16	34	2	2
	59	3	4	17	0	0
	61	3	4	9	0	0
	62 (*b*)	7	5	20	0	0
	63	4	4	19	0	0
	65	11	12	28	3	3
	67	3	3	26	0	1
	73 (*b*)	2	5	27	0	0
	86	6	5	20	2	1

(*a*) Salicylate of soda was commenced on the 2nd day.
(*b*) ,, ,, ,, 4th day.
(*c*) ,, ,, ,, 7th day.
(*d*) ,, ,, ,, 9th day.
(*e*) ,, ,, ,, 10th day.

[6] To be published in the Society's Transactions.

TABLE A.—(*Continued.*)

	No. of case.	Day of subsidence of pyrexia.	Day of subsidence of joint pains.	Day of discharge.	Relapses. P.	Relapses. J.
Class V.—100°—101°.	2	4	5	5	0	0
	13	2	6	15	0	0
	27	4	3	11	0	0
	29	4	4	19	0	0
	30	2	2	22	0	0
	31	4	3	8	0	0
	34	4	4	15	0	0
	36	4	3	51	0	0
	40(a)	3	5	58	1	3
	41	3	8	28	1	1
	45	3	5	18	0	0
	46	3	4	24	0	0
	48	4	7	28	1	1
	49	8	10	28	0	0
	53	3	16	73	1	2
	54	3	7	34	1	1
	55	4	11	83	4	3
	57	15	15	35	1	1
	68	36	3	85	3	6
	69	4	3	49	0	0
	78	13	10	17	0	0
Class VI.—100° and below.	15	4	5	22	0	0
	20	3	6	26	1	0
	37	5	4	53	1	0
	39	3	4	26	0	0
	56	2	9	48	1	2
	66	3	10	44	0	1
	74	—	2	13	0	0
	75	3	4	6	0	0
	77	2	9	17	0	0
	82	3	10	23	0	0
	85	2	2	6	0	0

(a) Salicylate of soda was commenced on the 7th day.

The results given in Table A show the primary pyrexia to subside in fifty-eight out of seventy-nine by the fourth day of treatment. In one case the temperature was never 99°, and in two it had fallen to normal before the salicylate was given. In some cases the pyrexia was more prolonged—e. g., to twenty-third, twenty-fourth, twenty-eighth, and thirty-fifth day of treatment (*vide* Chart No. 1).

In Table A the cases are arranged in the classes above-mentioned, and according to this the average duration of the pyrexia in each class from the commencement of treatment was as follows:—

	Subsidence on	Aft. treatmt. of
Class I. (4 cases), exclud. No. 25	5th day	4 days
Class II. (8 cases), exclud. No. 84	8th day	6·5 days
Class III. (15 cases)	10th day	8·2 days
Class IV. (23 cases)	7th day	5·5 days
Class V. (26 cases)	5·7th day	4·4 days
Class VI. (11 cases)	2·7th day	1·7 days

Thus the duration of the pyrexia is in tolerably exact relation to the maximum temperature attained—at any rate, when the latter does not exceed 103°.

The average duration of pyrexia calculated from the whole number of cases (with the exceptions named) was thus 6·4 days, the temperature becoming normal on the fifth day of the treatment by salicylate.[7]

2. *Duration of joint affection.*—This has been calculated upon the same plan as the pyrexia, with the result (*vide* Table A, and Chart No. 1) that 30 out of 80 cases lost their pain after four days' treatment, and 53 in six days. Of this number, 5 lost their pain on the first day, 10 on the second, and 2 before salicylate was given. In a few cases the joint affection was long-continued and persistent—most remarkably so in No. 84, now in the hospital.

As regards the relation of subsidence of articular manifestations, when treated by salicylate, to the severity of the primary fever, we have the following average results:—

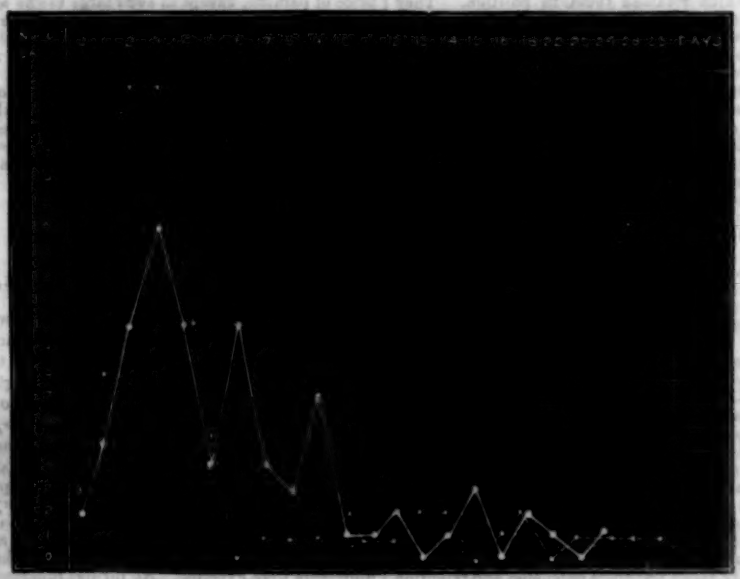
	Subsidence of joint pain.	After treatment of
Class I.	6·25th day	5·2 days
Class II.	6·25th day	4·7 days
Class III.	9·4th day	7 days
Class IV.	8 3rd day	6·8 days
Class V.	6 4th day	5 days
Class VI.	6th day	5 days

Here again Class III. stands highest, but not much above Class II. in yielding to the treatment. The average of the

[7] For the calculated average duration of pyrexia when the day on which the case was admitted is taken into account, see below, on "Total duration of illness."

CHART 1.

Showing the number of cases and the day of treatment upon which pyrexia and joint pain subsided.



Pyrexia is denoted by the dotted line, joint pain by the continuous line.

whole number gives a subsidence of pain on the 7·1 day from admission, or after 5·6 *days* of treatment by the drug.

I think we may infer from this that the salicylate did lessen the joint pain, especially as in those cases in which its administration was withheld for a time the pain did not abate. It further appears that although we have only to do with cases which are treated by the drug, such a cause as that of withholding its administration is sufficient to account for the difference between the day of subsidence of pain when calculated from admission, and when reckoned from the time of commencement of the drug.

(To be concluded.)

A BRISTLY BOY.

By H. E. CAUTY, M.R.C.S.,
SENIOR SURGEON, ST. GEORGE'S HOSPITAL FOR SKIN DISEASES, LIVERPOOL.

THE following curious case appeared at the hospital on July 9th, 1881.

W. R——, aged ten, somewhat imbecile but well nourished; on removing his clothes the upper part of the back, both shoulders, and down the outside of both arms, appeared covered with short bristles of a clear darkish-brown-yellow colour, acuminated apices, and very clean; these bristles were at the edges of the group gradually shortened from their full length of $\frac{1}{12}$ in. until they joined the skin, which was at the junction raised into polygonal flat discs, finally graduating off to the sound healthy skin of the hands, chest, and back. These bristles also existed between the buttocks, where their tips were black with dirt, and as they interlaced before the buttocks separated, the appearance was most singular. The feeling communicated to the hand on passing it over the shoulders was exactly similar to that of touching a coarse brush, and the bristles gave way under the touch, resuming an upright position afterwards. There were a few pink maculæ over the body and considerable scaly thickening on and around the patellæ. There were also a few ordinary comedones and sebaceous collections on the back. The pulse was quick with nervousness. Bowels confined. Urine free and healthy. Tongue clean; appetite good. Sleeps well. The bristles were expelled comedones, containing very few immature hairs and very little sebum, drying up into a horny substance. They were tolerably firmly attached, requiring more force to remove them than to extract a well-rooted hair; and when removed they left a small central depression surrounded by a circle of torn epithelium which retained them in position. They averaged 100 to the square inch, and had existed over three months. The boy was ordered mercurial aperient every third night, and to be well rubbed with olive oil and a few drops of carbolic acid. A week afterwards, all these comedones were softer, and those in process of expulsion much more visible. The bowels were now regular. Ordered three ounces of lard and half an ounce of glycerine, to be followed every morning by the benzine lotion. This treatment was continued until September 9th, when most of the comedones had disappeared. Some few remaining partially expelled had inflamed; and there were also some inflamed punctæ where the comedones had been. The lard and glycerine to be continued.

Three months afterwards this boy had an attack of herpes, when I again saw him. The skin where the first crop of comedones appeared is now perfectly soft, while showing not the least trace of their past existence. There are three small sebaceous collections of the ordinary character, about the size of a pea. But the whole surface of the back, which had hitherto escaped, is now covered with slight polygonal elevations with a minute central spot, as though a comedo was about to appear, or, failing to find an exit, had caused slight swelling. During the progress of this case, a solitary comedo made its appearance on the back; and the time of expulsion from first to last was six weeks. It will be interesting to notice if all the parts at first free should follow the course of those affected, which at present appears possible; if so, I am afraid a profitable subject for exhibition has been destroyed. There appears some family tendency to abnormal sebaceous secretion, as a brother, aged twenty, had his face, ears, and neck quite black with comedones of the ordinary character. The formation of comedones of an extra horny character is not very rare; but their expulsion and retention on the skin in such quantities is very uncommon.

TWO CASES OF AMPUTATION TREATED WITH EUCALYPTUS GLOBULUS

By EDWARD LAWRIE,
PROFESSOR OF SURGERY, LAHORE MEDICAL SCHOOL.

ON June 30th last I had occasion to perform a Carden's amputation of the thigh and Syme's amputation of the ankle, in cases of cancer of the leg and fungus disease of the foot Having seen in THE LANCET of May 21st the annotation on Mr. Lister's speech on Eucalyptus Globulus at the Clinical Society, I employed this antiseptic during the operations and in the after-treatment, it being understood that strict Listerism was followed throughout. Both cases healed without inflammation by the first intention, although the patients were old men and were exhausted, the one by malarious poison and the other by syphilis and an open cancer.

This brief record is sent to THE LANCET in order to bring to the notice of the profession a very simple plan of carrying out Listerism, which I have employed for some years, and which acted perfectly in the cases under report. It consists in preparing the gauze dressing at the time it is to be used instead of beforehand. A stock mixture is kept of four to six parts of resin, four parts of spirit, and two parts of castor oil. Carbolic acid, or any other antiseptic, is added to this in the proportion required, and the gauze is impregnated with the mixture at the time of use. In the present instance, as we did not know the proportion of the antiseptic Mr. Lister would employ, the gauze was simply wrung out of the resin mixture and then dipped in tincture of eucalyptus globulus, of which it took up a large quantity very readily. Evaporation was prevented by a macintosh covering fixed with a splint and bandage; and the only after-treatment consisted in opening this once or twice and moistening the gauze with fresh tincture of eucalyptus. This plan is put forward as an adjunct, and not as a rival, to Mr. Lister's perfect method of carrying out his own system. It involves the use of a wet dressing, and has certain disadvantages; but, in a country like India at all events, its advantages, foremost among which may be mentioned its cheapness and easy application, outweigh them. Here and in other tropical climates Lister's prepared dressings speedily become inert owing to the heat. The result is that, as you cannot tell how far the dressings have deteriorated, you may be deceived by them, and never feel confident in using them; and their employment is apt to be followed by disaster, and consequent disrepute to Listerism. Moreover, in India the price of paraffin, except in such large towns as Calcutta and Bombay, is almost entirely prohibitive of the preparation of gauze in the way Lister recommends. In short, while the prepared dressings of the antiseptic system are expensive, and liable, under many circumstances, to deteriorate or become useless by keeping, these objections do not hold good with regard to storing some such liquid as that mentioned above instead of the dressings; and this method possesses the great additional advantage that the antiseptic or its proportions can be varied without difficulty, delay, or waste, to suit the requirements of any kind of wound.

ON A CASE OF LOCKED TWINS.

By J. ARONDEL BARTON, M.B., C.M.

ON the morning of the 18th of August I was sent for to attend Mrs. C——, who was reported to be then "strong" in labour. On my arrival I found the patient to be a robust young woman, very short in stature, and eighteen years of age, and in her first labour. The nurse informed me that she had been in labour for over twelve hours, and that she had not expected to be confined until the end of October. On examination I found the vagina well dilated, the membranes ruptured, and the breech of a fœtus presenting well down in the pelvic cavity. The pains being very irregular and feeble I administered a subcutaneous injection of ergotine, shortly after which the pains became regular and strong, and the breech and body of the fœtus up to the level of the umbilicus were expelled. No further progress being made, I after a short delay passed my forefinger up over the thorax of

the fœtus to the neck, in the cavity of which I found a round mass, which I at once recognised as the head of a second fœtus, the chin of which was firmly locked with that of the presenting fœtus. I endeavoured by all the means that occurred to me to dislodge the two heads, but all my efforts were fruitless. At first sight it appeared to me that there was no way out of the difficulty except decapitation of the first or perforation of the head of the second fœtus; but, on further consideration of the fact that the age of the fœtuses was at most six and a half months, and that consequently they were of small size and easily compressible, and further that the pubic arch was very wide and the vagina well dilated, I determined to attempt to pass up the blades of the long forceps over the surface of the first fœtus, and to fix them on the head of the second, and try to deliver it before the other. This I proceeded to do, first administering chloroform. After considerable difficulty I succeeded in passing both blades up over the body of the presenting fœtus, and getting them locked on the head of the second, and then in a short time I had the satisfaction of delivering first the head, followed shortly after by the body of what was the second fœtus; the child was alive, and appeared to be somewhat over six months old. In a few minutes the other fœtus was also expelled, followed in due course by the placentæ. There was no rupture of the perineum, nor more than the usual quantity of hæmorrhage. The mother recovered without a bad symptom. The children of course died within a few hours.

The case is chiefly interesting from the fact of labour coming on at a sufficiently early date to allow of delivery without decapitation or perforation, as of course had the case gone on for a very short period longer such operative procedure as I employed would have been quite out of the question.

St. George, Bristol.

A Mirror OF HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

LONDON HOSPITAL.

ATROPHY OF THE MUSCLES SUPPLIED BY THE FIFTH CRANIAL NERVE, WITH ATROPHY OF THE ORBITAL FAT ON THE SAME SIDE; REMARKS.

(Under the care of Dr. WARNER.)

ALFRED C——, fifty-two years of age, employed as a messenger in the City, came under treatment in May, 1881, for a neglected subacute pneumonia of the left base, which cleared up under observation, and appeared totally independent of the interesting condition of his face. He was a well-developed, well-built man, about five feet ten inches in height, intelligent and healthy-looking, and carrying his years well. On looking at him the asymmetry of his face was striking. The left side was normal in all respects. The right side of the face presented evident signs of wasting of muscles, so that the bony prominences of the skull stood out in marked contrast with the left side. The right eyeball was deeply sunken into its orbit, adding greatly to the asymmetrical appearance of the face; the eyeball was healthy but for an old slight corneal scar, as to which no history could be obtained, its movements and the reactions of its pupils were normal. Atrophy of the temporal muscle left the fossa above the right zygoma almost empty; there was also very little, if any, fat in it; but there was probably little fat in any part of the face. The right masseter muscle, when examined with one finger in the mouth and another outside the cheek, was found very thin and wasted as compared with the left. The force with which the patient could bite on the right side was diminished in proportion to the atrophy of the muscles. The power to protrude the jaw and to move it laterally was not markedly impaired, and it could not be determined with certainty whether the pterygoid muscles were atrophied. The buccinator acted equally well on either side. Sensation was everywhere perfect. There was no affection of the facial muscles, and the palpebral fissures were equal (no lesion of the sympathetic). When seen one day in June, he was perspiring freely, and the sweat was equally seen on either side of the face. The patient is a gouty man, and has had attacks of gout during the last fifteen years; one attack occurred under my observation. There is no proof of syphilis.

The following is all the history of this affection obtainable. A tumour was removed from his right scapular region (probably fatty) thirty years ago; the scar is now visible. Soon after this operation he began to notice a change in his face; there was no sudden onset, no pain, and he did not seek medical advice for it.

Remarks by Dr. WARNER.—This appears to be an uncomplicated case of chronic atrophy of the muscles supplied by the motor division of the right fifth nerve, its sensory division being unaffected; it seems to be a case of progressive muscular atrophy analogous to the similar condition seen in muscles supplied by spinal nerves. The history of the affection dates from the operation for the removal of a tumour from his back; it seems possible that the shock of the operation may have started the affection. The man is a gouty subject, and in the uncertainty of the evidence as to causation it is worth while to recall to mind that in gouty patients tooth-grinding is very common—i.e., excitation of the motor divisions of the fifth nerves, and through them of the pterygoid muscles. As to the physiological teaching of the case, we have evidence that the buccinator has not its motor nerve supply from the trigeminal but from the facial. Atrophy of the orbital fat on the side of lesion is very interesting, and not easy to explain. There were no signs of lesion of the sympathetic, and the atrophy, if due to nerve control, must, I think, have been due to the fifth nerve. This raises the question as to the trophic influence of the fifth nerve. Cases are common, especially among children, where the face is in a very different condition of nutrition to the rest of the body, the face being fairly well nourished while the body generally is emaciated; the condition of fat on the face has often appeared to me a local trophic condition governed by the brain.

ROYAL LONDON OPHTHALMIC HOSPITAL, MOORFIELDS.

ECTROPION OF THE UPPER LID REMEDIED BY TRANSPLANTING A PIECE OF SKIN FROM THE ARM; REMARKS.

(Under the care of Mr. GEO. LAWSON.)

AN interesting case is just now under observation at this hospital, in which Mr. Lawson has transplanted a piece of skin from a man's arm into the upper eyelid for the cure of ectropion following a burn. The plan of the operation was the same as that originally adopted by Mr. Lawson in a similar case in the year 1870, and reported, as stated below, in the Transactions of the Clinical Society for that year. It is essentially based upon C. F. Graefe's modification of the so-called Tagliacotian method. It will be remembered that the particular operation of rhinoplasty revived by the Italian surgeon Tagliacozzi, and called after him, consisted in making a flap of skin and areolar tissue for the restoration of the lost nose at the inside of the arm, and leaving the flap connected to the arm by a pedicle. After the lapse of a certain time, the free portion of the flap on the arm was fixed to the stump of the nose, and when the adhesion between the two had taken place, the pedicle of the flap was cut through, and the arm set free. Reneaulme suggested that the separation of the flap of skin for the nose and coaptation of the parts should be completed at the same time. This was actually done by C. F. Graefe at the beginning of the present century. He entirely detached the flap of skin from the arm and fixed it to the stump of the nose. It was this procedure that Mr. Lawson followed in 1870, and has repeated again now. Since Mr. Lawson published his first case, the operation has been done by other persons, among whom may be mentioned Dr. Wolfe of Glasgow, in 1875; Dr. Wadsworth of Boston, U.S., in 1876; and Professor Hirschberg.

H. E——, aged fifty-one, an engine-driver, was admitted into the hospital on November 25th, 1881, on account of a severe ectropion of the right upper eyelid. His history was as follows:—Whilst at work driving an engine at a chemical manufactory, some chemicals near him exploded

and the liquor was blown over the right side of the face, including the temple, brow, and upper eyelid. He was taken to the Poplar Hospital and placed under the care of Mr. Brownfield. Much of the burnt skin sloughed and a large granulating surface was left. The healing of the wound was facilitated by grafts of skin placed on it whilst in the hospital.

On admission into Moorfields Hospital, there was a severe ectropion of the right upper eyelid caused by dense cicatrices. The tarsal edge of the upper eyelid was adherent to a line just below the eyebrow, so that the whole eyelid was completely everted. The cicatrices extended round the temple and brow, so that no healthy skin could be obtained with which to make a new eyelid. An incision was made just above the tarsal edge, and the eyelid dissected from its adhesions was made to fall over the eye. The tarsal edges of the upper and lower eyelid were then united at two points, and an oval-shaped piece of skin half an inch long, and a quarter of an inch wide, was cut from the inner side of the forearm, and laid upon the raw surface, and fastened in position by two fine sutures to the upper edge of the wound. The parts were then covered with a piece of lint smeared with vaseline and a compress of cotton-wool, with a bandage applied to keep the whole *in situ*. The patient progressed favourably; the cuticle desquamated from the new skin, which, however, retained its vitality, and completely united to the tissue beneath it. On December 23rd the patient was discharged from the hospital, well pleased with the result. During the healing process one of the bands of union between the tarsal edges gave way, so there was no occasion afterwards to divide it. The other band between the edges of the lids was left, and will be divided at a future date.

Remarks by Mr. LAWSON. — In cases of severe ectropion of either the upper or the lower eyelids, caused by the destruction of the skin from burns, scalds, or chemical escharotics, it is essential after the lid has been dissected from its false position, so as to fall over the eye, that the fresh raw surface should be covered with new skin. There are three ways in which this can be accomplished: first, by the Sicilian method, revived by Tagliacozzi in the sixteenth century; and second, by transplanting a portion of adjacent skin, leaving a broad pedicle, through which the nutrition of the part can be maintained until union has been established. (There is a case of this kind at present in the Middlesex Hospital under my treatment. The patient had had the skin of his face largely destroyed by a burn, and as the result there was an extreme ectropion of each lower eyelid. On each eye, with an interval of a few weeks between them, I have operated with good results. An incision was made just beneath the tarsal margin, and the lower eyelid, having been dissected from the adhesions it had contracted, was replaced in its proper position. The upper and lower tarsal edges of the lids were then united at two points, as first suggested by Mr. Bowman, and a large piece of skin was brought down from the temple, sufficient to form a new covering for the lid.)

The third method of treating these cases of ectropion is a revival of that of C. F. Graefe's (1818), with this difference: he detached a portion of skin from the arm to make a new nose; I have cut a piece from the arm to make a new eyelid. In the Clinical Transactions, vol. iv., p. 51, I published the case of a man on whom, in October, 1870, I made a new eyelid from two pieces of skin, of the sizes of a threepenny piece and a fourpenny piece, taken from the arm. I remarked at that time, "it remains for experience to decide how much larger portions can with safety be transplanted."

This operation is peculiarly applicable to those cases of ectropion where the cicatrices from the injury involve the skin around the eye, and there is consequently no healthy integument which can be transplanted.

MANCHESTER ROYAL INFIRMARY.

TRAUMATIC STRICTURE OF ŒSOPHAGUS; GASTROSTOMY; RECOVERY.

(Under the care of Mr. THOMAS JONES.)

MARY N——, aged nineteen years, a native of Blackburn, was admitted into the infirmary on March 5th, 1881.

Two years before while in service she accidentally swallowed a dessertspoonful of nitric acid. This was immediately followed by a swelling of the mouth and an inability to swallow. The œsophagus became the seat of intense pain, which extended even to the stomach. To counteract the evil effects of the acid a mixture of olive oil and milk was administered. On the following day she was made an in-patient of the Blackburn Infirmary, where she remained for three weeks. By the end of that time her power of swallowing had very much improved. This improvement, however, was of a temporary character, for in the last three months deglutition became difficult and uncertain. Some days she could swallow milk with comparative comfort, while at other times she had difficulty in swallowing saliva. Emaciation now commenced and proceeded with great rapidity.

In the early part of 1880 she sought advice at the Manchester Infirmary, and was admitted under the late Mr. Bradley. Soon after admission her weight was determined and recorded as 40lb. During a stay in the infirmary of nearly four months bougies were repeatedly passed, and she derived so much relief from the treatment as to enable her to swallow milk with ease, and to increase her weight to 5 st 2½ lb. She refused further treatment, returned home, and was lost sight of until her readmission in March last. In the interval deglutition had varied much, occasionally for a couple of days she would be quite unable to swallow any fluids.

March 8.—Three days after her readmission a small bougie was introduced through the stricture; its passage caused considerable pain, which was referred to a point internally corresponding to the xyphoid cartilage externally. Deglutition afterwards improved, and patient succeeded in swallowing a small piece of bread-and-butter; this, she said, appeared to remain at one spot for a little while, it then passed easily into the stomach. On the 20th the bougie was again passed; several unsuccessful attempts had been made between the 8th and the 20th. On the 22nd the bougie was introduced into the stricture, which seemed to commence about one inch below the upper extremity of the œsophagus. Swallowing became much more difficult after this attempt. For the next five days little or no milk passed along the natural passage; in consequence, it became necessary to administer nutrient enemata.

During April the patient took on an average three pints of arrowroot and milk daily. No appreciable quantity was swallowed at a time. She sipped the mixture until she finished it. Some days she was unable to swallow any fluid, then nutrient enemata were administered four times daily. Each enema consisted of an egg beaten up in four ounces of beef-tea or milk.

For the first ten days in May the patient swallowed small quantities of milk, and lived mainly upon the enemata. On the 11th she was unable to leave her bed, owing to the feeling of exhaustion she experienced whenever she made any effort. Emaciation was manifestly progressing. She was weighed at intervals of two and three days, and it was found that she was losing at the rate of one pound per diem. It therefore became evident that unless relief were speedily afforded, death from starvation would inevitably take place, and that at no distant date. As the extent of the stricture was uncertain, it was not thought prudent to attempt œsophagotomy. Gastrostomy was therefore determined upon, and its risks explained to the patient. She placed herself unreservedly in Mr. Jones' hands, and expressed a desire that any operation should be performed which was calculated to give her a chance of escape from her distressing condition.

The operation was determined on, and it was decided to divide it into two stages, to be performed at different times with an interval of five days.

On May 14th the first part of the operation was performed. It consisted in the exposure of the stomach and the approximation of its peritoneal and muscular coats to the margins of the skin incision.

This procedure was carried out in the following manner:—The patient was anæsthetised by a mixture of alcohol, chloroform, and ether, and a slightly curvilinear incision (four inches in length with convexity to the median line) made from a point opposite the seventh intercostal space on the left side, and about half an inch from the costal margin. The structures of the anterior abdominal wall were then carefully divided, some small vessels were twisted, and the peritoneal cavity was opened. The lower border of the stomach with its attached omentum at once came into view, and the finger, introduced through the peritoneal opening,

readily felt the left lobe of the liver. The stomach was now gently pulled forwards into the wound, and held in this situation by means of forceps, while two strong carbolized silk ligatures were passed obliquely through its outer coats, at a distance of about three-quarters of an inch from one another. The organ was steadied by these ligatures, and its peritoneal and muscular coats secured to the lips of the skin-wound by nine chromicised catgut sutures. The position of stomach, included by the sutures, was elliptical in shape, with the long diameter (one inch) in the direction of the skin incision. This part of the operation, performed under the carbolic spray, was concluded by bringing together the tissues at the upper and lower extremities of the wound and applying the usual antiseptic dressings.

The patient was some time in recovering from the effects of the anæsthetic. Her pulse remained slow and weak, but improved very markedly when she awoke. As soon as consciousness was regained an enema, consisting of the yelk of an egg beaten up in three ounces of beef-tea, with ten minims of Battley's solution, was administered about 1 P.M. The enema was repeated at 3 P.M., and at 5 P.M. without the opiate. At 9 P.M. an enema of three ounces of milk with ten minims of Battley was given. Two ounces of milk were similarly administered every two hours during the night, and on the following morning until noon, when two ounces of peptonised beef-tea were substituted. Tongue moist and covered with a slight white fur at the sides. No tendency to sickness. Has slept well in the night. At 9 P.M. temperature 97°.

On the 16th she complained of occasional slight pain in the vicinity of the wound. At 5 A.M., when the pain troubled her, the temperature was 98°; pulse 78, small, compressible; respiration 18, regular. Tongue moist, cleaner than yesterday; washed her mouth occasionally with iced or soda-water. Notwithstanding the slight pain she rested fairly well during the night, and had an enema of peptonised beef-tea or peptonised milk every three hours. Enemata were repeated every three hours night and day. On the 17th and 18th the bowels, which had not been moved since the operation, were relieved by a simple enema.

On the 19th she slept very well; the pain had entirely left her. She felt comfortable but made some complaint of thirst. Skin moist and cool. Pulse 80, full; temperature still subnormal. She was taken to the operating theatre, and the antiseptic dressings which had remained untouched since the first operation were now removed. The wound looked healthy, and adhesion had taken place between the edges of the skin incision and peritoneal covering of the stomach. The organ was steadied by the silk sutures, and its walls perforated with a tenotomy knife. Through the opening, which was situated about the centre of the exposed surface, a small non-elastic catheter was introduced. The catheter was fastened *in situ*, about an inch projecting into the organ. The wound was then dressed with lint and carbolic oil. Soon after the operation, about three ounces of milk were injected into the stomach; one end of a piece of india-rubber tubing was secured on to the catheter, while the other end carried a glass funnel; through this she was afterwards fed. Enemata in small quantities were ordered as before.

On the 20th the patient was quite free from pain. Temperature at midnight 96·8°; at eight A.M. 97·8°; pulse 84, full, regular; respiration 20. She had half an ounce of peptonised milk by the stomach at four P.M. and ten P.M.

On the 21st patient's face was a little flushed; temperature 97·6°. This morning at eight o'clock it registered 96·8°; no pain; pulse 80, soft, full; respiration 20. Tongue much cleaner, and more natural. An ounce of milk was poured into the stomach four times yesterday. Enemata are still administered, only in smaller quantities. The wound was dressed with carbolic oil; no discharge. There was a thick lymph on exposed surface of stomach, no redness or tension about stitches; catheter withdrawn, and a piece of No. 4 elastic catheter was inserted without any difficulty. The flannel and elastic tubing were fastened on to the catheter, and half a pint of milk poured into the stomach.

On the 22nd the wound was dressed; no inconvenience whatever; pulse 92, respiration 22, temperature still subnormal; tongue clean, rather red at tip. Had four half pints of milk by stomach yesterday; to continue the same quantity; an occasional enema of peptonised beef-tea (two ounces) to be given. On the 23rd the temperature early in the morning was 98·6°, at 8 A.M. it had fallen to 97·6°; pulse 92, full, soft; respiration 22, tongue clean and moist. Wound dressed, catheter removed, to be introduced at time of feeding.

On the 24th the wound was dressed; exposed surface of stomach cleaning. The quantity of milk administered by stomach four half pints daily; besides this, she had a few enemata of beef-tea. There was no regurgitation through the artificial opening in the stomach; pulse 90, respiration 23, temperature 96·6° at midnight; 98·2° at 8 A.M., tongue moist. This morning the bowels were well moved after a simple enema.

On the 25th all the sutures were removed. Surface of wound much cleaner. As there was some difficulty experienced in introducing feeding-tube, it was allowed to remain in the opening. Pulse 104; respiration 22. Patient said that the sensation of hunger which she at times experienced was readily satisfied by the introduction of milk into the stomach. The saliva did not occasion any inconvenience. She was able to swallow this secretion without much difficulty. Catheter replaced by a small bone tube, which was more easily introduced through the opening. There was a considerable elevation of temperature to-day; it was due to a sharp attack of toothache which she suffered.

On the 27th patient was much better. Toothache had entirely left her. Temperature 98°; pulse 84; respiration 20. A couple of skin grafts were placed on the granulating surface of stomach. She had three pints of milk daily by the stomach as well as six enemata of peptonised beef-tea (three ounces each) during the twenty-four hours. She sat up in the ward for a few hours yesterday.

The progress of the case continued to be eminently satisfactory. She soon began to recover her lost weight; and by the middle of July had gained two stone and one pound, being at the rate of three and a half pounds per week.

Patient, according to promise, returned to the infirmary at the end of September. Her appearance indicated perfect health. She had not only preserved the state of nutrition in which she left the institution in August, but had increased her weight by 8lb. Particulars of the case were mentioned to the members of the Manchester Medical Society on the evening of the 5th of October, and the patient was exhibited at the same meeting.

Food (which chiefly consists of milk) is still administered by the artificial opening in the stomach, and the patient is not inconvenienced by any regurgitation of the fluid.

Remarks.—It is deserving of careful notice that the stomach was not opened at the first operation, and that five days were allowed to elapse before the artificial aperture was made. We cannot overrate the importance of this procedure, first suggested by Mr. Howse, for I believe that herein lies the secret of the success which has lately attended gastrostomy. When the dressings were removed at the end of five days, it was found that firm union had taken place between the opposed peritoneal and other surfaces. The viscus could now be punctured without any risk of its contents extravasating into the peritoneal cavity.

This method enables us to perform the first and most important part of the operation with antiseptic precautions, thereby reducing to a minimum the chances of peritonitis. It is beyond my purpose at present to discuss the larger question as to when it is prudent to advocate the formation of an artificial opening into the stomach. I will, however, venture to express the hope that in cases of malignant stricture of the œsophagus gastrostomy will be undertaken while the patient is in a tolerably good condition, and not delayed until a fatal issue is imminent.

Medical Societies.

PATHOLOGICAL SOCIETY OF LONDON.

Squamous Epithelioma of Upper Jaw.—Mixed-cell Sarcoma.—Morphœa Alba.—Xanthelasma.—Neurotic Excoriation.—Bilharzia Hæmatobia.—Gastric Ulcer.—Bovine Tuberculosis.—Annular Stricture of Intestine.—Internal Strangulation of Intestine by Band.

THE annual meeting of the Pathological Society was held on Tuesday last, January 3rd, the President, Dr. S. Wilks, in the chair. Nearly the whole of the allotted time was devoted to the usual work of the Society, the business of the annual meeting being got through with commendable despatch.

Mr. BUTLIN showed a specimen of Squamous Epithelioma

of the Upper Jaw, removed by Mr. M. Baker. The patient was a woman, aged fifty-eight, she had suffered from pain in and swelling of the upper jaw for two months before admission to hospital. The alveolar process and hard palate were affected. All the teeth had disappeared on the affected side, but in the socket of one of the molar teeth was the opening of a sinus leading into the antrum, which was filled with malignant growth. At the operation the walls of the antrum were found quite destroyed, and the growth more extensive than expected, as much as possible was removed; the woman died five days after from exhaustion. The microscopical characters were those of squamous epithelioma with numerous cell-nests. It appeared to begin in the alveolar process and spread upwards. The disease was very insidious in its origin, and had spread very rapidly. The case closely resembled the one shown by Mr. Butlin last year. Mr. Butlin also showed a small Tumour, removed by Dr. Whipps from the first phalanx of a woman, aged twenty-four; it was about the size of an almond. It was a mixed-cell sarcoma with well-marked alveolar structure, and some giant cells. Sarcomata of the fingers are not common, and such a well-marked alveolar structure is also rare; the stroma was different from a carcinomatous stroma and from that of the alveolar sarcoma of Billroth. He thought it arose from the outer surface of the periosteum.

Mr. STARTIN showed three living specimens of Skin Disease. One was a woman, aged fifty-nine, who had a large patch of morphœa alba on the right thigh. He stated that the disease consisted of hyperplasia of the fibrous tissue of the corium, which gradually destroyed the other structures—papillæ, follicles, vessels, and nerves. The second case was a child, showing well-marked yellow patches of xanthelasma on elbow, fold of buttocks, and hams. The younger brother of the child shows signs of the commencement of the disease. The third was a case of neurotic excoriation in a child, aged four. The rash was on the abdomen, thighs, and ham, the skin looked as if rubbed by some hard substance; the attacks had been periodical, every two or three weeks.—Dr. CROCKER could not understand why the third case was called neurotic excoriation; there had been an abundant discharge, and parts of the patches discharge now, and similar patches had existed on the scalp and behind the ear. He failed to see any evidence of nerve influence. Many cases of neurotic excoriation have an element of doubt about them. Dr. Sangster showed one at the Congress which proved to be self induced.—Mr. HUTCHINSON proposed that a committee should be appointed to examine Mr. Startin's case of xanthelasma; he had never seen quite a similar case. The child also has some curious bony outgrowths from the fingers. Mr. Hutchinson thought the patches in the third case were peculiar, those on the belly were like herpes zoster. He thought there was a neurotic element in it, although it was eczematous in nature.—Dr. STEPHEN MACKENZIE agreed with Dr. Crocker, that the third case was one of eczema. Mr. Hutchinson, Dr. Crocker, and Dr. Sangster were requested to examine and report on the case of xanthelasma.

Dr. ZANCAROL showed specimens of Bilharzia hæmatobia from patients dying in Alexandria. One patient was an Arab, who died with dysenteric symptoms. Vegetations were found in the large intestine, which showed bilharzia ova between the glandular and muscular coats. Another specimen was a section of hypertrophied bladder, with vegetations. The mucous membrane was thickened, and in its deeper parts was crowded with ova of bilharzia. The male adult worm of bilharzia was also shown. It was removed from the portal vein of a patient. It was about an inch long. The female is shorter and more slender. Dr. Zancarol stated that the parasites are only found in the portal, mesenteric, hæmorrhoidal, and vesical veins. The ova in the urinary tract have a lateral spine; those in the intestine have a terminal spine. He suggested that the parasite, and particularly the ova in the urine, had some influence in the production of vesical calculi. Dr. Zancarol also showed a number of stones from patients in whose urine or bladders bilharzia hæmatobia had been found.—Dr. N. MOORE stated that in a patient who acquired bilharzia three years ago there have recently been found filariæ in the blood during the night. He asked if this had been observed before. These parasites no doubt enter the body by the mouth; but he had heard that in Africa the natives believe they enter by the urethra, and therefore tie its orifice when swimming.—Mr. BRYANT asked if there were any special symptoms of the condition of bladder caused by the parasite.—Dr. ZANCAROL had never seen filariæ in natives with bilharzia; but once a friend of his found something very like filaria. The bilharzia exists in Arabs who drink the undistilled water of the Nile, and Europeans are only attacked when they have been found to drink the same water. The chief symptom of this form of cystitis is hæmaturia, and the diagnosis is made by the microscope. The best way to find the ovum in the urine is to try to get out some yellow and dirty specks, and in them the ova are sure to be found. The embryos cannot live more than twenty-four hours in the urine; they are like pumpkin skins, surrounded by ciliæ, and possessing active movements. Many patients infested with bilharzia live for years, even without serious suffering, only occasional cystitis and hæmaturia. The disease requires no special treatment; once in the body, it is impossible to destroy the parasite, but good hygienic treatment will secure immunity from suffering for years.—Dr. WILKS thanked Dr. Zancarol for bringing forward the very interesting specimens.

Mr. KESTEVEN showed a specimen of Ulceration of the Stomach, sent to him by Mr. J. R. Hill. It was from a single woman, aged twenty, and who had been in good health till the day before her death, when pain and vomiting came on, and death occurred from sudden collapse next day. There were several small ulcers along the lesser curvature, and one ulcer quite through the stomach. The liver was small, soft, and yellow. The case illustrated well the insidious nature of the disease, and the fact that symptoms may be produced only when perforation occurs.

Dr. CREIGHTON showed a specimen of Bovine Tuberculosis from an Antelope, the Nil Ghi, which of all ruminants is nearest to the bovine species. On both surfaces of the diaphragm the characteristic growths were seen. The lungs contained small whitish material in a racemose arrangement. The structure was much more that of sarcomata and fibromata than of tubercle. This animal was about three years old, and was born in Paris. The same condition has been found in the same species at Hamburg. The disease was confined to the thorax, except for one small growth in one kidney, which, like the others, had a small central calcareous nodule. It is not known whether the disease exists in the animals in their wild state. In the Hamburg case it was distinctly hereditary, as it usually is.

Dr. STEPHEN MACKENZIE showed two specimens of Annular Stricture of the Bowel. One was from a woman aged sixty-one, who had had chronic constipation with small, hard, lumpy motions; rectal examination showed no obstruction. Glauber's salts gave her temporary relief; the belly was greatly distended, and there was severe pain; during the last week of her life she had diarrhœa. The colon was found greatly dilated down to twelve inches from the anus, where the sigmoid flexure was found much contracted, only admitting a No. 8 catheter. The ring-like stricture extended vertically from half to three-quarters of an inch. The second case was an elderly lady, who had complete obstruction after chronic constipation. After death the colon was found enormously distended down to a stricture in the sigmoid flexure, which admitted the end of the little finger; the colon was thin and soft. In the first case colotomy would have afforded complete relief. The seat of this disease is usually in the descending colon, and in nature is epitheliomatous or glandular cancer.—Dr. COUPLAND asked if there was any ulceration in the cæcum; in many of these cases the fæcal accumulation leads to ulceration in the cæcum only, as if the main stress of the obstruction were felt there.—Dr. MACKENZIE said there was perforation of the cæcum in the second case, and pinhead ulcerations in the cæcum in the first case; this ulceration was the usual cause of death in these cases.—Dr. MORRISON stated that he had recently had a case of old constriction of the upper end of the rectum in which the stricture had become destroyed, and only a cicatrix left behind; but the colon was enormously distended, and fell down over the rectum.

Mr. J. KINGSTON FOWLER showed a specimen of Obstruction of the Small Intestine, caused by Cords formed from the Great Omentum. It was removed from the body of a boy aged thirteen, admitted into the Middlesex Hospital on Nov. 7th, 1881, under the care of Dr. Cayley. On Oct. 27th he received a kick from a bare foot on the right of the abdomen. Symptoms of obstruction appeared shortly afterwards, and continued up to Nov. 9th, when abdominal section was performed by Mr. Hulke. A cord was found constricting a portion of the ileum near the cæcum. This was divided

and the obstruction relieved. The patient died collapsed five hours afterwards. At the post-mortem examination the great omentum was found lying folded up below the transverse colon. From either edge of it a cord, consisting of omental structures, was seen to pass downwards towards the pelvis. That on the right side, about twelve inches long, and rather smaller than a goosequill, crossed the ileum at its juncture with the cæcum, then turning upwards, it joined the left cord for a considerable distance, and became lost in the mesentery. It was not merely attached to the peritoneum, but was intimately blended with it. The left cord, which had been divided below its junction with the right, was ten inches in length, and of a similar size and structure. Its distal end was attached to the mesentery on the right side, in a similar manner to that of the right cord. Two structures somewhat resembling the vermiform appendix were found attached to the other parts of the peritoneum. The obstruction was probably caused by a portion of the ileum slipping beneath the left (divided) cord at the time the blow was inflicted. These cords may have been formed by inflammatory adhesions between the omentum and mesentery. Long continued traction may have drawn out the peritoneum, and produced the appearance of complete fusion with it at the points of attachment; or the omentum may have become entangled in two appendages of the peritoneum resembling those seen in the specimen, and have gradually assumed the form of a cord on each side. In either case the omentum must have been twisted, so that the left edge became adherent on the right side, and *vice versâ*.

The Society then adjourned.

MEDICAL OFFICERS OF HEALTH SOCIETY.

A MEETING of this Society was held on Friday, December 16th, Dr. J. W. Tripe, President, in the chair.

A report from the Council was brought up recommending the Society to petition the Local Government Board to cause the reports of the medical inspectors on local outbreaks of disease to be in future printed as Parliamentary papers, or be otherwise made available for those who may desire to purchase them. The Council also recommended the Society to send a copy of this resolution to the North-Western Association of Medical Officers of Health, who were desirous that the Society should co-operate with them in requesting that these reports, as well as the reports of the medical officer to the Local Government Board, should be sent free of charge to all medical officers of health. The Council also presented a report on the subjects referred to the Royal Commission appointed to consider the hospital accommodation in the metropolis for infectious diseases. The report excited much discussion, it being felt by some members that it was not desirable the Society should take any step in the matter. Eventually it was resolved that the Society should express its views to the Commission, and the report of the Council was then considered. After further discussion it was resolved not to make reference to any existing small-pox hospital, seeing that several were the subject of investigation, and it was also resolved not to express an opinion on the limits of extension of small-pox from a small-pox hospital, this question still being *sub judice*. The following report was then adopted:—

"The available accommodation for small-pox patients is insufficient to meet the demands which might at any moment be made upon it by a recrudescence of the existing epidemic. So far as respects the number of beds available for the treatment of fever cases, the existing accommodation appears to be fairly sufficient for present wants. The hospitals, however, are few in number and necessarily remote from many parts of the metropolis. The advantages of a limited number of hospitals for the whole metropolis, and under one central authority, preponderate. The authority should make provision for all classes of persons, and admission to the hospitals should not entail pauperisation. Provision for mild cases of small-pox and for convalescent cases should be made outside the metropolis. If this were done, probably eight well-placed hospitals, containing 150 beds each, would suffice for the small-pox cases that must be treated in hospitals within the metropolis—i.e., cases too ill to be removed to any great distance from their homes, and no small-pox hospital should contain more than 150 cases at any one time. To each hospital for fever and for small-pox cases a district should be allocated, and only overflow cases in emergencies should be removed to any other hospital than that of the district properly assigned to such hospitals. The adoption of this principle would obviate many objections to the existing system of hospital accommodation. The hospital authority should have the power to acquire sites for hospitals compulsorily, and subject to the hospitals being conducted with reasonable care and according to prescribed regulations. The authority should be protected from legal proceedings, so as to secure the public against the loss of the benefits arising from such institutions. The Society wish to submit to the Royal Commission the necessity of legislation to secure compulsory notification of infectious diseases, and compulsory powers to enable the sanitary authority to enforce the removal to hospital of the infective sick not possessed of lodging or accommodation enabling them to be properly treated and isolated."

Dr. SEATON of Nottingham made a few remarks on the constitution of a sanitary staff in large towns, and objected to the duty of "chief scavenger" being undertaken by Dr. Yeld, late medical officer of health to Sunderland, and which it was proposed by the Town Council should devolve upon his successor. Dr. Seaton considered that the medical officer of health in a large town would find his time sufficiently occupied by work in relation to epidemic diseases, and by the preparation of statistical information for the purposes of the Artisans' Dwellings Act, &c., and that if he were not held responsible for the proper performance of those duties which ought to belong to a scavenging department he would be in a better position to criticise the work.

After some discussion, it was resolved to ask the Council to consider and report on the subject.

Reviews and Notices of Books.

Diseases of Women: A Manual for Students and Practitioners. By ARTHUR W. EDIS, M.D. Lond., F.R.C.P., M.R.C.S. London: Smith, Elder, and Co. 1881.

THE task of writing a handbook on any subject is a most difficult one; but of all subjects none is probably so difficult to handle as that of the Diseases of Women. Apart from the rarity of pathological facts, the peculiarities of the seats of these diseases prevent free investigation and reduce objective facts, palpable to many observers, to the level of inductions dependent on individual observation, though these are eventually stated broadly as facts. The result of this general substitution of inductions for facts has been unbounded assertions on one side and unbounded contradictions on the other, from which no escape is furnished by the comparative experience or good faith of either side. The intended writer of a handbook must do one of two things: he must either compile from all sources and merely state the cases on all sides, or he must make up his mind independently and state his conclusions, remembering that the "middle course" is no safe guide, and that in most cases a deliberate choice must be made. In the instance of a book for students this is emphatically the case: the writer must speak with authority on most points, remembering that he is probably giving first impressions to a number of minds, young and ready to believe anything they are told about a subject of which they know nothing. This responsibility, which cannot be shirked, is a great one. On the manner in which the task is performed depends the result of sending out into the world a number of men, observant, sceptical, and chary of doing harm where they can do no good, or superficial, greedy of novelty, and regarding any deviation from a procrustean standard as an excuse for the knife.

The work before us is the product of a gynæcologist of large experience, and bears the stamp of great diligence and earnestness of purpose. The author has obviously spared no trouble to produce a good and trustworthy manual, and we should imagine that his task has occupied some considerable time. Any criticisms we offer will be made with full recognition of these qualities, without which the most

brilliant talent is useless. The real question to decide in all these cases is this: Can this book be recommended without reserve as the first guide of a student?

The scope of the book is large, including some subjects, such as that of Extra-uterine Gestation, not usually embraced by these manuals, and omissions are rare. There is, however, no adequate account of retroversion of the gravid uterus. The chapter on Extra-uterine Gestation is one of the best in the book; another very good one is that on Ovarian Tumours. The arrangement is generally sensible, but we fail to see why cystitis should be considered among diseases of the vagina; this is, however, a small matter. But it is not so much by the great as by the trivial everyday subjects that a manual is to be judged. Indeed, we will boldly propound the paradox, that the most trivial are the most important, because the practitioner is always meeting them, and because bad practice with regard to them is not only a constant injury to the pockets of patients, but is less likely to produce fatal results, and therefore more likely to remain unchecked. We will therefore at once consider the subject of granular degeneration of the cervix uteri (p. 164).

This affection is said in some cases to give rise only to leucorrhœa, in others to more serious disorders, some of which materially interfere with the patient's well-being; to arise in some cases from displacements; and often to cause (if the patient be gravid) intense nausea and even abortion; under proper treatment "a cure may be safely predicted;" when of long standing it is generally secondary to vaginitis, endometritis, displacement, &c. If laceration of the cervix is present, this must be repaired; in virgins, after vaginal injections and suppositories have been tried, it must be treated by the speculum. We also learn (p. 215) that it is one of the causes of cancer. We fail to trace Dr. West's Croonian Lectures where this subject was thoroughly debated, and the conclusion arrived at that this affection has no symptoms proper to itself, though it may be associated with other complaints; that its character is absolute want of change, as a rule, in any direction; that it is, in fact, an unimportant affair. If displacements cause it, what (we may ask) are they not said to cause? With the question of laceration of the cervix we will deal presently. If Dr. West is right (and clinical experience only confirms him), what is to be thought of treating virgins through the speculum for so trivial a complaint? But perhaps the most important point of all is prognosis; knowing, as we do, how large a number of women apply to us simply from fear of cancer, are we to tell them (as we have hitherto been glad to do) that there is no special danger even if this affection is present, or are we to return evasive answers, or are we to shake our heads, or are we to acknowledge the correctness of their fears? There is no more important question in gynæcology than this, and we confess that we think the author has hardly acted up to his principle of giving an "impartial account" in entirely ignoring this view, backed as it is by the highest authority and by facts and experience, even if he does not accept it.

We pass now to a subject closely allied, that of Laceration of the Cervix Uteri (p. 175), a matter which has been exciting of late immense attention in America. Suffice it to say that Dr. Edis throws in his lot without much reserve with the class of American gynæcologists which is *not* called the "bloodless" school (we are not quite sure what the opposite school is called). All sorts of ills are put to the account of this very common state—cancer, sterility, hopeless ill-health. What woman under the circumstances could refuse the operation? We shall look forward with interest to the publication of Dr. Edis' successful cases, on which no doubt his opinion is founded; but may be we do him wrong, and, reading (p. 185) that this operation is "perhaps the most successful one in uterine surgery," we are not sure whether we perceive caution or pleasantry such as that of the American humourist who observed that some singularly obscure person was "perhaps the most remarkable person in the United States."

Another common ailment is Leucorrhœa (p. 456). The term is a bad one, including discharges of all sorts and colours. It is, besides, ambiguous as applied to the cervical secretion; we do not know nor can we learn whether the term is intended to include the normal or to be reserved for the abnormal secretions. But if leucorrhœa appears as a disease, it is certainly incorrect to describe "a glairy albuminous fluid like unboiled white of egg" as a sign of disease. This is distinctly given (p. 130) as a sign of chronic cervical endometritis, and (p. 472) as a cause of sterility. We know of no system of pathology which accounts normal secretion a sign of disease, and will add that if this were so, the unborn fœtus requires often to be cured of the above complaint—a task we fear beyond the reach of diagnosis, even though amenable to treatment at the hands of some ingenious gynæcologist. With regard to displacements, the author accepts implicitly the doctrines of the mechanical school, including that of obstruction at the angle of flexion, without mentioning the fact that the importance of flexions is entirely denied by at least a respectable minority, and that not one of the specimens of flexion shows the alleged obstruction. Is this quite fair to the innocent and confiding student?

In debating the question of Division of the Cervix (p. 39), a long extract is given from an American author, who claims to have performed this operation 337 times, and pronounces that in the absence of complications "no procedure offers more certainty of success, more freedom from danger." All we can say is that his experience is unusual, and that the operation is now seldom performed in England. Dr. Barnes' remarks apply only to the os externum, and cannot justly be put into the same category.

In considering Obstructive Dysmenorrhœa, the author says (p. 447): "Allowing that the loss is eight ounces and the average duration four days, that leaves two ounces to pass within the twenty-four hours—that is, 960 drops; this divided by twenty-four gives forty drops every hour, or about two-thirds of a drop every minute. Now, when we remember that the cervical canal is at least three-sixteenths of an inch in diameter, it seems difficult to imagine how this could offer sufficient impediment to the passage of so small a quantity at a time as above calculated." We quite approve of this statement, but fail to reconcile it with the theory of obstruction by the angle of flexion and the surgical treatment recommended (p. 336)—viz., "all cases of obstructive dysmenorrhœa in which hæmatocele is likely to occur [whatever that may mean] should, whenever practicable, be dealt with surgically."

In dealing with Vaginismus (p. 498), it is stated, on the authority of Thomas and Marion Sims, that all cases can be easily and safely cured. The author makes no distinction between purely functional and secondary vaginismus due to local causes, nor mentions that even the birth of a child at full time fails to cure some cases.

We are glad to find that he has modified his advice with regard to what we may call the postural treatment of sterility, though he does not seem to understand the passage of Lucretius which he quotes (p. 476); at least, he appears to think (p. 504) that "more ferarum" means "in the lateral decubitus." The objects described (p. 521) as "pediculi pubis" are not the animals, but their eggs. This shows a want of knowledge of natural history which might prove dangerous to the student.

We can only mention a few of the smaller errors. In the prescriptions, "aquæ ad ℥j.," "aquam ℥j.," "ad Oj. aquam," are wrong, and should be "aquam ad ℥j.," "aquæ ℥j.," and "aquam ad Oj.," or "ad Oj. aquæ" (*passim*). "Scybalæ" should be "scybala" (*passim*). To the term

"igneous hysterotomy" we have only two objections (similar to those which Cuvier expressed to the proposed definition of the crab)—that the womb is not the body treated, and that the treatment is not by cutting; the list of "tomies" is too long already to receive unlawful intruders. "Hydatid fremitus" is *not* a "decisive" sign of a hydatid (p. 277); a "serres-fines" (p. 417) requires alteration; so do "cum quiniæ et strychniæ" (p. 429), "ferri oxidi magneticum" (p. 437), "hæmophylia" (pp. 463 and 465), "sodii salicylate" (p. 517), and "forcep" (p. 419). Finally, we must say we envy the author his power of diagnosing pregnancy by smell (p. 6), and uterine catarrh by pain on the top of the head (p. 140).

We look confidently to the removal of these blemishes, and can only say that if Dr. Edis devotes as much care to the revisal of a second edition as he has to the compilation of the first, we shall have great pleasure in recommending to the class of readers whom he addresses a book which, for the reasons stated above, in spite of the evident care expended on it, we think hardly calculated in its present state to produce the best type of practitioner.

ROYAL COLLEGE OF PHYSICIANS.

DEBATE ON DR. WILKS' RESOLUTION RESPECTING HOMŒOPATHY.

A MEETING of the College was held on Dec. 27th, Sir W. Jenner, Bart., President, of which we gave a summary last week. There were present about fifty Fellows, including Sir W. Gull, Drs. A. Clark, Beale, Sieveking, Wilks, G. Johnson, Quain, Bristowe, Pitman, Wilson Fox, and Maudsley.

The PRESIDENT announced that he had nominated Dr. G. Johnson to be Harveian Orator, 1882. A report was read from the examiners, and licences were granted to the successful candidates. A report from the Council was adopted. It contained a reply to a query addressed by the Medical Acts Commission as to a Preliminary Scientific Examination, and was to the effect that the College did not think it desirable to add to the subjects of entrance examinations, and had provided for examination in natural science in its first examination for the licence. It also proposed to hold the several examinations for the licence in the months of January, April, July, and October, the first examination to take place in the last week in each of these months. Students are recommended to pass the first examination as soon after registration as possible, and that an interval of two years should elapse between the first and second examination and the final one.

Dr. WILKS then moved the following resolution:—"The College considers it desirable to express its opinion that the assumption or acceptance by members of the profession of designations implying the adoption of special modes of treatment is opposed to those principles of the freedom and dignity of the profession which should govern the relations of its members to each other and to the public. The College therefore expects that all its Fellows, Members, and Licentiates will uphold these principles by discountenancing those who trade upon such designations." In the course of his remarks he said that the resolution was instigated by an event which had stirred the profession at the beginning of the year. The conduct of the Fellow in question received the approval of leading members of the profession, and in that approval Dr. Wilks concurred. But the circumstance had raised the general question of consultations with homœopathic practitioners, and the question was constantly being asked whether the College was going to speak or to give any opinion on the matter, which had been freely discussed, not only by the medical journals, but by the daily papers. There were those who wanted at once to propose to the College that it should forbid any consultations on the part of its Fellows with homœopaths. But an attempt to enforce such a veto could not be carried out; it would bear no pains or penalties, and it would be ridiculous for the College to pass a strong resolution one day and find that some of its leading Fellows disregarded it the next day. And it might also be said that there are some members and licentiates of the College who are homœopaths, and a penal clause could not be enforced against them. Moreover, there would be a legal difficulty in such enforcement. It was imperative on any college like that to grant its licence to everyone who passed its examination, irrespective of his opinions. The College could not hand a candidate his diploma one day and the next take it from him; and if the College could not deal with those who hold its diploma and practise homœopathy, how could it deal with others who err less grossly? There could be no doubt that the clause relating to the conferring of its diplomas was made in favour of the homœopaths, and that the spirit of the Act of Parliament was against ourselves. As the year went on a revulsion of feeling set in, and some distinguished Fellows declared they could see no dereliction of duty in such consultations. But all the arguments hitherto used in the medical press and elsewhere, both *pro* and *con.*, were bad, for they made the issue rest upon a question of *doctrine*. The question was not one of doctrine. He (Dr. Wilks), for his part, repudiated the notion that there was any medical doctrine in reference to therapeutics. It is a device of the enemy to say that there is a doctrine. It was what the public and the lay press said, and he was sorry to see the medical press take it up in the same sense. He did not know or recognise any such doctrine as "allopathy." He felt himself at liberty to prescribe what he liked; he might give physic when the College would not; but his liberty of action was inviolate. It was wrong, then, to say that this was a question of doctrine. Suppose a theme were set by the College on any subject permitting of difference of opinion in treatment—e.g., the action of colchicum in gout,—one might deal with it on the doctrine of contraries, another on the reverse; but who could refuse each the right to hold what view he pleased, whether right or wrong, on the subject? Those who would co-operate with homœopaths, recognising this, call themselves liberal, and regard those who hold aloof as illiberal. But the word "liberal" cannot be applied in relation to a scientific question. William Harvey directed by will that an oration should be given every year by one of the Fellows. He did not dictate what the lecturer should say. He (Dr. Wilks) in holding that office one year laid down what he thought was philosophical doctrine, and next year his successor contradicted it all. There was no restriction of opinion at all by the College. Its members were entirely free to hold what opinion they chose. But this matter of consultations with homœopaths and others is a question of *morals*. The difference between a professional man and a tradesman he took to be this: a professional man has the guidance and care of those who seek his advice; a tradesman is one who caters for the public, supplies what the public demands, and his dealings vary from day to day according as caprice and fashion dictate. A medical man begins by acquiring a knowledge of the structure and functions of the body, and then learns how best he may treat its derangements. He brings all his knowledge to bear on the treatment of the sick, but he does not trade with it, he takes it back and utilises it again. Now, as it is by *treatment* that the medical man lives, the tradesman-like view of medicine would be to lay greater emphasis on treatment alone. Dr. Wilks then asked: What is a quack? A quack, he said, is one who has to do with treatment only. The honourable professional man gives advice and is known apart from the line of treatment he adopts. The man who advertises pills is only a pillmonger. Who is Holloway apart from his pill, or Alcock without his plaster? On this basis he was not surprised at its being said that homœopathy is the *quintessence of quackery*. For homœopathy says that medicine is simply a question of treatment. It is nothing more than a glorified quackery, to suit the superior intellects of lord chancellors and archbishops. A particular friend of his own had, however, thought it not wrong to advise co-operation with homœopaths, influenced no doubt by the knowledge that they included respectable and honest men. But he must admit that their system was based on quackery. Their writings proved this; even the very man about whom this question had arisen had written a book in this spirit—a very mild one compared with most of their writings, winding up with a general abuse of all other methods of treatment. The man who most abuses our profession is a homœopath; he is also an anti-vivisectionist, and says that

we do not want to know anything about physiology, and in its place puts a wonderful system of metaphysics as the basis of therapeutics! Mr. Barnum, who wrote a most instructive book on quackery in all its forms, discusses what charlatanism is, and says that it is not robbery that makes the charlatan, but simply the proclaiming himself by a flourish of trumpets. Not long ago he (Dr. Wilks) was asked to see a friend of his, a gentleman who had heart disease and dropsy. He was superseded at the last moment by a well-known homœopath. In two or three weeks the patient was much better, and he told Dr. Wilks of the great good he had obtained from the homœopath's advice. Dr. Wilks asked to see the prescriptions. They consisted of digitalis and iron. Dr. Wilks said, "This is good treatment, and exactly what I should have written had you consulted me. Why did you prefer the other consultant?"—"Why, because he had a 'principle' guiding his practice." Is not that, which implies that others act without a principle, charlatanism or humbug? With reference to the other point—the plea of liberality—there were difficulties in the way of recognition of homœopathy of a practical kind. A general practitioner, a licentiate of the College, who had been much exercised by the homœopaths, had said to Dr. Wilks that if Fellows of the College consulted with such he could see no reason why he should not; and what would he do then supposing he had a homœopathic prescription before him which he would not know how to read? He would have to ask the College to widen its curriculum, to insist that homœopathy should be taught in the medical schools, and that candidates for the licence should be examined in it, so that they might understand such things and not be placed in a dilemma when they became practitioners. Dr. Wilks had brought forward the resolution in these terms because a strong penal resolution could not be enforced; because the time had come for a clear understanding of what is meant by quackery or charlatanism, and of the grounds why we refuse to meet homœopaths—grounds which do not involve questions of doctrine, but of morals. He had brought it forward to prevent any more hot-headed people than himself trying to commit the College to impracticable courses, to show how a homœopath differs from ourselves, and to test the advisability of expressing the opinion of the Collge in a way which should benefit its members and other practitioners. He declared that the better men among the homœopaths knew well that this question of designation was the real point of difference. As long ago as June, 1877, Dr. Wyld expressed this in a letter to *The Times*, where he tried to show that sectarianism had no place in medicine, and that there should be perfect liberty given to anyone to adopt any theory or line of practice, provided he did not trade on a distinctive name. Dr. Wilks thought it was wise for the College to pass this resolution, for if it were known that they had done so it would tend to prevent intending members of the profession from taking up with homœopathy as a trade. Of course, that could not be entirely prevented, for some seem to be born quacks; but it would be much help to a teacher if he could have the support of his College in condemning those of his pupils who, from worldly-minded motives, were inclined to do so.

Dr. BEALE, one of the Censors of the College, seconded the motion.

Dr. ALEXANDER, of Halifax, having made some remarks,

Dr. ANDREW CLARK said that if he understood Dr. Wilks' elaborate statement, either Dr. Wilks had not justifiable grounds on which to base his resolution, or he was inconsistent, and had missed the true moral ground on which Fellows should base their refusal to meet with homœopaths. If he applied it to quackery in general it should have been so stated, for there were other forms of quackery quite as prevalent and more pernicious than homœopathy—quackery in look, in manner, in gesture, in conversation—which should be discountenanced. The true ground was that when two men meet in consultation holding radically different opinions as to principles of treatment, it is impossible for them to hold a true consultation. No harmony and no good result could accrue in such a consultation. It must be a false one, and anyone sharing in it is guilty of an immoral act, and if the College permitted this it was participating in an immoral act.

Dr. BUCKNILL agreed with much that Dr. Wilks had said, but also agreed with Dr. Clark that Dr. Wilks was inconsistent in his conclusions. The resolution did not attack or even censure those persons against whom it was directed. It would even include those who are honestly pursuing some special line of treatment—e.g., Dr. Althaus might be styled a medical electrician, as he advocates treatment by electricity; Dr. Maclagan, for his advocacy of a special mode of treatment of rheumatism; and Mr. Lister, for holding the principle associated with his name. All these and many others are, by holding special "views," to be linked with homœopaths, and would hardly feel honoured by such companionship. What Dr. Wilks really wished was an expression of opinion on the part of the College that should assist the weaker brethren, and he (Dr. Bucknill) could not see why this should not be expressed in a definite and positive way. He, too, felt with Dr. Wilks that difference in doctrine alone did not influence him in declining to consult with a homœopath; but the true reason for his refusal was because he could not believe that a well-educated medical man, fully instructed in physiology and pathology, could, if honest, be a homœopath. If he were so instructed he could not *honestly* practise homœopathy, which has no basis in these subjects. It was well known, also, that homœopaths frequently give their patients a choice of the "system" on which they would be treated. He desired therefore to move an amendment to the effect that the College, considering that no competent medical man can honestly practise the so-called homœopathic system, is of opinion that no Fellow, Member, or Licentiate of the College should consult with any who adopt that system.

The amendment was duly seconded.

Sir W. GULL observed that the College was treading on most dangerous ground, and was about to be committed to a definite expression of opinion which might have much result for good or ill. When the President of the College took the course he did in the case that formed the basis of Dr. Wilks' motion, he did so on the simple ground of, *What is best for the patient?* He (Sir W. Gull) also declined the consultation on the same ground. We should always do that, and knowing that it is not best for the patient to co-operate with anyone whose principles are opposed to ours, he would not meet any Fellow of the College over a case of peritonitis who had made up his mind to give purgatives in such cases; or in a case of aneurism with one who considered that it was best treated by letting the patient walk out in all weathers, as was the advice given to his knowledge by a homœopathic practitioner in one case. He doubted if he could go entirely with Dr. Wilks. One of the most respected Fellows of the College does not agree with him (Sir W. Gull) in this matter, and is he to be put under a ban for this? It was impossible to co-operate with a man who has a double set of convictions. No Act of Parliament touches the Fellows of the College, who are chosen by their associates, and they should agree among themselves that any Fellow should under all circumstances do what he thinks best for his patient. He thought the proposition as a whole was quite right, and that it should go forth, with the full authority of the College, that it could not countenance a system which is unparalleled in fact.

Dr. WILSON FOX said that the original position assumed by Dr. Wilks appeared to cover the whole ground raised by Drs. Clark, Bucknill, and Sir W. Gull. Sir William had stated the whole truth as regards the position of consultants, who accept the right to decline to co-operate, when it would be ridiculous to meet if it were known that they only met to differ. But the liberty of the profession to do that had been impugned. We had been told we were a privileged class, and were bound to go when the public called, whereas we are only bound to go when we know that we can help them. He concurred in the fact that it is absolutely right and proper for each to practise as he pleases; but such right does not apply as against the whole medical profession. With reference to Dr. Bucknill's mention of certain names as associated with lines of treatment, it must be remembered that no designations have been assumed or accepted by any of these gentlemen, and on the same reasoning he himself might be styled a medical electrician because he prescribed electricity, or a hydropath because in certain cases he considered hydropathic measures useful; and in the same sense all surgeons might nowadays be termed of the "aseptic" school. The evil lay in sectarianism with an object. It may be in a measure for good to testify for the truth, but it was sinning against the whole profession to declare that one special line embraced all truth. The whole question of consultations lies inside that, but the larger question is the only one with which the College can deal. He did not think they could suppress homœopathy; but he did not

think any man could honestly practise it, and it was not right for him to use a title showing that he differs from the rest of the profession. If he be honest he will not seek to meet Fellows of the College in consultation; if he be dishonest they would not meet him. The assumption of a distinctive "title" was the essential point. He thought it well for the College that it should express its opinion in the matter. The medical public were asking for a guide, and because the College could not meet all forms of misdoing, was that a reason why it should decline to deal with those which it could meet? That College was almost the only medical body which had any rules of distinct ethics in print, and they could hardly add one of less value than Dr. Wilks' was. He did not think the public were to blame for the position they took. The College need not fear the public. For public opinion was more likely to react injuriously on the question if the College declined to assert the principles of freedom and of truth. It would not increase true liberty by allowing larger liberty. Individual liberty was not interfered with by the resolution, which he trusted the College would adopt.

Dr. PRIESTLEY suggested, and Dr. Wilks consented to, the addition of the following words to the original resolution: "While the College has no desire to fetter the opinions of its members in reference to any theories they may see fit to adopt in the practice of medicine, it nevertheless thinks it desirable....."

The PRESIDENT (Sir W. Jenner) said that the College knew well that his opinion was decidedly against the Fellows meeting homœopaths in consultation; and Sir W. Gull had fairly expressed his own view in stating that they should only be animated by the good of the patient. The public had nothing else to demand of them. If he knew beforehand that the person whom he was asked to meet was one with whom he could not possibly agree, he could not meet him; they had no common ground. He would not even place it on the high moral ground on which Dr. Wilks had based his resolution, but on the broad principle that our profession is intended for the good of the public, and that no good can come, but only evil, from such consultations; they must lead to malpraxis. It had been said that we should meet them for purposes of diagnosis. "Am I," said Sir William, "a mere puzzle-solver? Am I to be paid so much for solving a puzzle? I go to do the patient good, to ease or prolong his life." The homœopathists can do no more. He met at the house of a distinguished gentleman a homœopath whom he had long known, but not that he was a homœopath. He (Sir William) had attended members of his family, and knew him for an honourable man. Being asked to meet him over a new case, and after the consultation observing that he prescribed full doses, Sir William said to him, "I have an idea that you are an honourable man, and should like to know if it is true what I am told, that you are a homœopath?" His reply was that he did practise homœopathy when he thought it "suitable;" and in this case he would do whatever Sir William sanctioned. "But," replied Sir William, "you are an honest man, and practise according to your convictions; suppose you were called to this patient in the night, and had to change the line of treatment, how can I be sure that you may not think it right to prescribe according to homœopathy? The patient's welfare is concerned in this; and therefore, it being for the good of the patient, I would rather not meet you again." And accordingly Sir William withdrew from the case. No one would doubt what his feelings and opinions were on this subject. But as a Fellow of the College, he doubted the wisdom of the College sanctioning Dr. Bucknill's amendment. The College should not commit itself to the opinion that "no competent medical man could honestly practise homœopathy," and he hoped that a resolution, if carried, would be unanimously agreed to. He thought the resolution proposed by Dr. Wilks one which the College could pass, implying that the Fellows will not meet men who protest that they follow special systems, a resolution which would not only meet the case of the homœopaths but of others, such as the "dosimetric" school, that had recently sprung up. By passing it the College would set a wholesome example. The profession looked to them for an expression of opinion, and such a resolution would satisfy the great bulk of the profession.

Dr. BUCKNILL withdrew his amendment.

Dr. A. CLARK asked Dr. Wilks to state in his reply what the Fellows were to do in regard to consultations with those who neither assume nor accept a distinctive title, but practise one "system" one day and another another day.

Dr. WILKS briefly replied.

Dr. ALEXANDER moved the previous question, but his motion, not being accepted, fell through.

The resolution proposed by Dr. Wilks was then put and carried unanimously.

Authority was given to the President to affix the College Seal to the Murchison Trust Deed, and the meeting adjourned.

THE WINTER EXHIBITIONS OF THE ROYAL ACADEMY OF ARTS AND THE GROSVENOR GALLERY.

IT is more than twelve years since the custom of holding an exhibition during the winter of works of the Old Masters, and deceased Masters of the British School, was instituted by the Council of the Royal Academy. No sign of exhaustion of the sources from which the works are drawn shows itself in the present exhibition, which will at least hold its own in interest with any which have preceded it. The collection includes noble examples of various painters who flourished between the fourteenth and nineteenth centuries. The older works are hung together in one of the galleries, which presents some admirable specimens by Domenichino, Crivelli, Giorgione, Holbein, Corregio, Murillo, Raphael, Titian, Matsys, Tintoretto, Veronese, and numerous others of the old school. Amongst the more modern masters we find beautiful examples of Canaletto, Cuyp, Hobbema, Lelienberg, Lambert, Nicholas, and Gaspar Poussin, Velasquez, Van Dyck, Wouvermann, and Wynants. It is flattering to our national pride to observe that the works of English masters like Reynolds, Turner, Hogarth, Calcott, Romney, Morland, Cotman, Wilkie, do not suffer by comparison with the efforts of these giants. There are several less-known works by Turner, which are of extraordinary beauty and interest. A painting by Hogarth of "The Graham Family" gives an idea, when we remember the subjects which the painter usually chose, of the wide grasp of his art which he possessed, and which is scarcely recognised. The collection is indeed one full of interest, and a visit to it, in galleries the lighting of which by Swan's electric lamps leaves nothing to be desired, is a recreation which will be fully appreciated by the public, and by none more than the hard-worked members of our profession.

New Bond-street has become as much identified with art as Grosvenor-street or Brook-street is with physic, and foremost amongst the collections is that which the Grosvenor Gallery now presents in its Winter Exhibition. The Gallery is mainly devoted to a vast collection, though even now, we believe, scarcely a complete one, of the works of G. F. Watts, R.A. More than two hundred paintings by this remarkable painter are hung on the walls of Sir Coutts Lindsay's elegant Gallery, together with a small but excellent collection of water-colour drawings by various hands; and a visit to this interesting exhibition may well be recommended to those who find in the contemplation of beautiful works of art the best kind of rest to brains jaded with professional cares. Broadly speaking, the works of Watts, as here presented, may be classified under two heads. Allegorical subjects, in which one does not know which to admire most, the delicate and subtle composition or the perfectly harmonious arrangement of colour, constitute what to many will be considered the higher and more important side of his work. The portraits, on the other hand, will appeal probably still more forcibly to the tastes of the majority of the visitors. A portrait by Watts is always something far removed from the work of the ordinary portrait painter, whose aim is to produce a likeness which shall be striking to even the uninitiated. In the portraits by Watts it appears to us that the painter's effort is to portray, as far as the materials employed will admit, not exclusively, or even so much, the outside presentment of the sitter as his individuality and character. The subjects of these portraits are, almost without exception, persons of historical interest, and in these circumstances the peculiar skill of the painter has ample room for producing works of the highest interest. Apart from the inherent importance and beauty of this collection, we cannot help being lost in admiration at the evidence of untiring industry and faithful work which is furnished by such an array of masterpieces.

THE LANCET.

LONDON: SATURDAY, JANUARY 7, 1882.

CONSIDERING the wide divergence of opinion among some of the "leaders of the profession" respecting the propriety of a Fellow of the Royal College of Physicians meeting in consultation, as in the case of the late Earl of BEACONSFIELD, a reputed homœopathic practitioner, and remembering the way in which the last annual meeting of the British Medical Association was used by the principal speakers, notably Dr. BRISTOWE and Mr. HUTCHINSON, to effect a reconciliation with homœopaths, and that no serious attempt has been made by the Council of the Association to disclaim the doctrine enunciated by these gentlemen, it is not surprising that the College of Physicians has been moved to take up this question, and that it has come to a unanimous resolution to discountenance those members of the profession "who trade upon such designations as imply the adoption of special modes of treatment." The unanimous action of the Fellows of the Royal College of Physicians not only supplies a complete answer to the views advocated by Dr. BRISTOWE and Mr. HUTCHINSON at Ryde, but it confirms what we have always alleged to be the true state of professional opinion respecting consultations with practitioners who assume designations implying special modes of practice and treatment. Nevertheless, we cannot regard Dr. WILKS'S resolution as at all clear on this subject, and his speech at the College of Physicians, fully reported elsewhere, does but scant justice to those medical moralists who for half a century have shown the impossibility of medical men who follow the teachings of science and experience co-operating with those who take for their sole guide in therapeutics the absurd and discredited dogmas of HAHNEMANN. We admit that practically the only part of homœopathy which now survives is the name, and that this seems to be retained, except by a very few practitioners, for "purposes of trade"—that is, to catch the patronage of people who have a *penchant* to be treated, as they say, "on principle." We are perfectly and literally warranted in saying this. The two essential peculiarities of HAHNEMANN'S doctrine—the law of similars and the administration of infinitesimals—have been publicly disclaimed officially in our own columns by the Vice-President of the Homœopathic Society. Why, then, retain the "homœopathic" label? Why, but for the purposes of trade? For the exclusion of homœopaths from consultation and other courtesies, we cannot blame anybody but homœopaths themselves, who in retaining the name either do so because they believe in the homœopathic doctrines, or because they think it will pay to profess to do so. We agree with Dr. WILKS that there should be the most perfect freedom in a free country and in a liberal profession, but we go a little further than he does in asserting our freedom. We claim the freedom to refuse to meet two men; he only one. He would commit us to refuse to meet the man who gives out that he is a homœopath and allows himself to be consulted as such, though, strange to say, he excuses a consultation with one who so posed before the public, and yet at a supreme moment, and in the case of an illustrious patient, was ready with a complete denial of having acted homœopathically. But, if we understand Dr. WILKS aright, he would be ready to meet a simple honest man who might propose the billionth of a grain of ergot in post-partum hæmorrhage, or as much quinine in ague. Ordinary minds will agree with Sir WILLIAM JENNER and Dr. CLARK that there is something false in consultations with men who, however honestly, hold such crotchets. By all means let them hold them, but in the name of common sense do not compel others who have more light to meet them. There can be nothing in proper freedom to require two to walk together who do not agree, and it needs little acquaintance with crotchet-mongers and homœopaths to know, as Sir WILLIAM JENNER well pointed out, that if we do suffer ourselves to be drawn into consultations with them, we shall find ourselves compromised and placed in false positions. It is a little hard on those who have so successfully combated the absurdities of homœopathy to be told that they have raised false issues. The attitude of regular medicine to homœopathy has been abundantly justified by the confessions of the degenerate disciples of HAHNEMANN and by the discredited position of homœopathy in Europe, which, in all its universities, has not one chair of homœopathy. Homœopathy would be much further discredited in the eyes of the public were its practitioners not in the habit, with very defective candour, of using the ordinary means and medicines of regular therapeutics. Under such circumstances it is but fair to ask for the dissolution of all homœopathic societies and the abolition of the name and designation. Meantime we must think with Sir WILLIAM JENNER and Dr. ANDREW CLARK that it is the part of all practitioners who realise the gravity of their calling to enter into no consultations which may involve the recognition of absurd and discredited doctrines, whether held innocently or for trade purposes.

It is well to have at length an authoritative expression of opinion, but the speech of Dr. WILKS at the College of Physicians—fully reported elsewhere—shows, what we pointed out in discussing Mr. HUTCHINSON'S remarkable address at Ryde, that the Corporations are "sore let and hindered" in expressing their views on consultation with homœopaths. In providing that the Licensing Bodies shall not seek to impose on any candidate for a licence or diploma an obligation to adopt or to refrain from adopting the practice of any particular theory of medicine or surgery as a test of admitting him to examination or of granting a certificate—as the 23rd clause of the Medical Act of 1858 does—it is clear that the Licensing Bodies are under a certain restriction, which does not obtain in the case of a voluntary association like the British Medical Association. In plain terms, it is evident that if the leaders of the British Medical Association had done their duty and given the members a fair, open opportunity of discussing this great question in medical ethics, the necessity would not have arisen for the discussion of it by the College of Physicians, and we should in all probability have had a bolder and clearer exposition of the ethics of consultation with homœopaths than we can find in the somewhat vague and cautious resolution of Dr. WILKS

IT should never be forgotten that insanity and the insane have their social as well as their purely scientific and medical aspects. Although the sequestration of persons of unsound mind is in a primary sense—as we are accustomed to look at the matter—necessary for remedial purposes, society has a claim to be protected from the perils which would undoubtedly attend the neglect to isolate and restrain the insane. The dangers to which the community may be exposed are illustrated by three recent cases. First, that to which we alluded last week, in which a woman was found to have been mad at the time of her marriage, or to have become so immediately after the ceremony; second, that in which a man who was alleged to be insane some years ago effected his escape from an asylum; and, third, that of a man who was a few days ago found travelling in a railway carriage without a ticket, whose eccentric behaviour attracted attention, and who was subsequently found to be a lunatic at large. In the first of these cases social wrong had been done, in the second mischief was apprehended, and in the third timely discovery probably prevented some untoward occurrence. We must face the fact that when the mind is deranged the body must be sequestrated, or, at least, placed under adequate control in the interests of the general community.

The difficult duty of enforcing such isolation of the insane as may be actually needful is much embarrassed by the fact that there is no satisfactory mode of publicly determining whether or not a particular individual is a fit and proper person to be placed in confinement. Judicial proceedings in lunacy are too costly to be applicable in more than a small proportion of cases; and even when recourse can be had to trial before a Master, with or without a jury, the result is by no means so uniformly just and equitable as to inspire confidence. We do not always feel sure that the subject of an inquiry in lunacy has had fair play or that his case has been rightly adjudicated. A forensic struggle is manifestly an unseemly mode of determining whether a man is ill. The question at issue is one which ought to be proposed to medical experts. It is, however, obviously impossible that it should be so proposed as long as medical opinion is only regarded as *evidence*, and is wholly excluded from the idea of *judgment*.

It is the too common practice of legal authorities and lay censors to sneer at the testimony of experts. This is unreasonable. If legal acumen were solely exercised at the bar, it would make a more ridiculous exhibition than medical skill presents to observation under the existing order of things. No case is so bad but that a barrister or any number of barristers can be found to present it in the best of possible lights before a tribunal. No one impugns the honour of the bar because its members act thus. It is recognised that counsel are doing their best for their clients within the limits of accuracy and truth. It is the Bench that explains and holds the Bar in check. There is no Bench in medicine. It is all Bar with our profession. And yet the unthinking and hasty to condemn judge us harshly, because they discover what they call "special pleading" in the court practice of medical experts. Create an order of medical judges, or assessors to the judges, and there will be an end of this misconception. At present we are only barristers engaged for, or against, a side, and it follows that we must be pleaders.

It is necessary that the insane should be placed in confinement, and that the community should be adequately protected from their incursions, but there is need of an impartial tribunal, readily accessible at all times, and without undue cost to the suitor, before which his claim to be restored to the privileges of personal freedom and self-control may be impartially adjudicated. It is monstrous that a poor creature can be legally placed and kept in imprisonment without appeal, and that this should be done privately at a single interview in any dark corner.

Recent events have shown that, both as regards the protection of the insane and the protection of society, the Commissioners in Lunacy are practically powerless, and therefore useless. They cannot either liberate a sane man or confine a madman. The utmost they are able to do is to sit in, more or less, solemn conclave at Whitehall, and, by their clerk, verify the *legal* accuracy of the certificates under which the inmates of asylums, public and private, and the "single patients," such as chance to be more known to the Commissioners, in private houses are held in confinement during—not Her MAJESTY'S official pleasure—but the personal pleasure of the "friends" who have signed their orders. So far as the lunatics confined under these certificates are concerned the Commissioners have no personal knowledge of them. They never see—even in the asylum crowd—one-half of the total number. The majority of patients are admitted, and either die or are discharged within six months of their admission, and the Commissioners visit only *once* a year, not always thus often.

If ELLIOTT was found to be of sound mind before he left the asylum, he ought to have been liberated, and the appeal made to the Commissioners on his behalf ought to have produced an inquiry, even though the application came from a stranger. Those who addressed the application to Whitehall were possibly ignorant of the fact that only those who interest themselves in placing an alleged lunatic in confinement can take him out, and that the Commissioners in Lunacy have nothing to do with the insane. Their whole concern is with certificates and asylums. Again, if ELLIOTT is still insane, he ought certainly not to be at large. The certificate has, however, run out, as the "escaped lunatic" was not recovered within the specified period, and now he can, whether really insane or sane, laugh at the utter defeat and humiliation of those who have so long held him in bondage on purely technical legal grounds. When will the common-sense intelligence of the people resent the long continuance of this supremely ridiculous, unfair, and unsafe state of matters, and press for the reform our legislators are unaccountably loth to concede?

We lay the greatest stress, in this view of the question at issue, on the needs of society, and we say those needs are not satisfied. The community is not protected. There are those outside asylums who ought to be under control, just as, we believe, there are many in confinement who might be out with advantage to themselves and to society. It is "a muddle;" and the muddle will be the worse if what awaits us—perhaps in the ensuing session—is only a little official meddling and muddling, inspired at Whitehall and approved at Lincoln's Inn.

THE physiology of the sensations which are connected with the supply of nutriment to the organism has received less systematic study than corresponds to their importance. Intimately connected as they are with the maintenance of life, their very simplicity and fundamental characters render their analysis and investigation difficult, although their normal mechanism and morbid perversion are of the highest importance in connexion with the maintenance of health and the phenomena of disease. Some points regarding one of them—thirst—are the subject of an instructive article by Professor NOTHNAGEL in the current number of VIRCHOW'S *Archiv*.

It is well known that the sensation of thirst expresses an insufficiency in the amount of water in the organism, whether this is the result of a deficient supply or of an abnormal loss. Why, however, is thirst referred to the mouth and throat? Is it because the nerve endings in this region are specially stimulated by the deficiency of water, or is the sensation of thirst of purely central origin, and only referred to this region. The scanty experimental researches on the subject teach but little. A remarkable case, however, is related by NOTHNAGEL which throws some light on the question. A man was kicked in the abdomen by a horse and knocked down, striking the occiput against the hard ground. He was not stunned, but could not walk on account of the severe pain in the abdomen and back of the head and neck. Previously well, the patient immediately after the accident began to feel extreme thirst, and this continued so great that in the next three hours he drank about five pints of liquid. The first urine was passed two hours and a half after the commencement of the thirst, so that the latter was not in any way dependent on polyuria. No injury to bone could be detected; the temperature was normal, the pupils small. The patient complained constantly of the intense thirst. Local pain in the abdomen and occiput from the injuries quickly passed away, but the thirst continued; the tongue and throat were moist, the skin usually perspiring. The thirst was unabated during the three weeks that the patient remained under observation. It was uninfluenced by treatment, and became more intense every day about noon. Nothing but large quantities of water relieved it, and the amount taken daily varied from about one to four gallons. The quantity of urine secreted daily was about three-fourths the amount of water taken; its specific gravity varied from 1002 to 1010. The case appeared thus to be one of pure, uncomplicated polydipsia. There was not any morbid state of the mouth or throat to which the thirst could be referred; there was no loss of liquid to cause it, and the thirst was clearly in some way the result of the accident. NOTHNAGEL believes that the thirst must be ascribed to a central effect of the blow on the occiput. If this view be correct, the question arises, To what part is the injury to be referred? What is the position of the thirst centre? Neither the pain in the occiput and neck, nor the contraction of the pupils, which was present at first, affords any distinct localising indications, since the pathological significance of each of these symptoms is uncertain, and each passed away while the thirst continued. Nevertheless, the probabilities are in favour of a localisation of the thirst-centre in the pons or the medulla.

A central origin of the sensation of thirst is also rendered probable by the analogous sensation of want of breath—"air-hunger" as it has been termed—which may arise in the medulla, independently of any deficient supply of oxygen from disease of the respiratory organs. Moreover, on the assumption that the sensation of thirst is of peripheral origin—is due to excitation of the nerves in the mouth and throat,—such excitation must pass up these nerves to the centre, to the nuclei of the nerves, and thence to the centres of consciousness. *A priori* there is no improbability in the assumption that the first central station of the sensation—the central endings of the nerves concerned—may be just as susceptible to a direct stimulation as is the analogous centre for the respiratory functions.

This case is of considerable interest also in its pathological bearing on the symptoms of diabetes insipidus. The frequent dependence of this disease on injuries to the central nervous system is well known, although it is probable that the causal lesion may be situated not only in the medulla oblongata, but anywhere between the calamus scriptorius and the kidneys. Most authors believe that in this disease the polyuria is the primary condition, the result of a morbid state of the renal vaso-motor system, and this is probably true of a majority of the cases. When the thirst is primary it has been customary to separate the cases as examples of polydipsia. The following distinctions between the two morbid states have been formulated by KNEIZ. In polyuria the water is withheld, more urine is passed than by a normal individual under the same conditions. With an equal consumption of water the polyuric patient passes more urine than a healthy person. The secretion of water taken begins later, and progresses more uniformly in the insipid diabetic than in the healthy individual. KNEIZ conjectured that a primary polydipsic patient would, in these particulars, behave as a healthy person, but this has not previously been corroborated. The only distinction which can at present be certainly relied upon between the two conditions is that founded upon the mode of commencement, and it is evidently only in such rare cases as that above related, in which the symptoms commence suddenly, that this test can be applied. But the clear indications of this case make it highly probable that in some other cases in which the polyuria has been supposed to be primary, the real relation is the converse. This case afforded, also, an opportunity for observing the conditions of the urinary secretion in an undoubted case of primary polyuria. Regarding this it may be noted that the amount of urine was always distinctly, and often considerably, less than the quantity of liquid taken. The perspiration was not lessened, but, on the contrary, appeared to increase in proportion to the amount of liquid ingested. Most of the water which did not pass away by the kidneys probably escaped through the skin. Limitation of the amount of water had the same effect on the patient as on a person in health; the urine immediately fell, even to below the normal, and there appeared thus to be no withdrawal of water from the tissues. In this respect the case corroborated the criterion of KNEIZ above referred to.

THE Report containing the answers given by the Council of the Royal College of Surgeons of England to the Secretary to the Royal Commission on the Medical Acts, and published

in our columns last week, is in more respects than one an interesting document. As regards professional examination and registration, the answers are in all essential particulars similar to those sent by the Royal College of Physicians (see THE LANCET, 1881, vol. ii., p. 197). Both Corporations recommend the adoption of a Conjoint Scheme for each division of the kingdom by the co-operation of the existing licensing authorities. In this way no person could register as a legally qualified practitioner unless, after a duly recognised general and professional examination, he had passed complete examinations in medicine, surgery, and midwifery. In consideration of this unanimity between the two Royal Colleges, and in deference to professional opinion, it is certain that the Royal Commission in its forthcoming Report will recommend the institution of a one-portal system, though whether by an independent Board appointed by the State or by a combination of the existing corporations may be doubtful. The rest of the Report is otherwise interesting. The tables, showing the receipts and expenditure of the College during the five collegiate years from 1876 to 1881, furnish some striking information. The annual receipts for the last five years have averaged £15,360, while the average expenditure for the same time has been £15,235. The receipts for the Membership examinations have averaged £10,500, while the payment for Examiners has been £4400. The receipts for the Fellowship examination, on the other hand, only averaged £635, while the payment of Examiners amounted to £740, thus entailing an average annual loss, in fees alone, of £105. The Report also states that since the beginning of the century the College has expended £50,000 in the purchase of house property and Government securities. The library of the College has cost during the same period no less than £40,000. "Finally," the Report concludes, "whilst the College has received, at different dates, Parliamentary grants amounting to £42,500, for the enlargement of the buildings devoted to the reception of the Hunterian Collection, it has contributed out of its own resources £42,000 for the same purpose, and about £200,000 for the preservation and improvement of the magnificent anatomical collection of which it has undertaken the guardianship for the use of the scientific world, and therefore for the benefit of the public."

Annotations.

"Ne quid nimis."

THE ELECTION TO THE SENATE OF THE UNIVERSITY OF LONDON.

AT the meeting of Convocation of the University of London on the 10th inst., three names will be sent up by that body "to be submitted to Her Majesty for selection therefrom of a Fellow of the University." Balloting papers have been issued for that purpose, and, according to custom, the name of the graduate that stands first on the poll will probably be selected to fill the vacancy in the Senate. The last time Convocation exercised its privilege was in January, 1880, when Mr. W. Shaen, M.A., was chosen, receiving 535 votes; Mr. (now Sir F.) Herschell, 177; and Dr. Weymouth 115. The election before that was in June, 1876, when Sir W. Jenner was elected, receiving 633 votes; Mr. Shaen, 334; Dr. R. Barnes, 251; and Mr. Cooper Forster, 247. The candidates on the present occasion are—R. Barnes, M.D., G. Buchanan, M.D., and S. G. Newth, LL.D. The last-named gentleman has probably been nominated by his friends in view of the next vacancy that Convocation may be asked to fill; for it has become a well-established custom for the graduates to select in turn as their representative either one who holds a degree in medicine or science, or one who has graduated in arts or law. This time the contest rests between Dr. Barnes and Dr. Buchanan, as we have previously intimated. Each of these gentlemen has a large number of supporters, and each of them would worthily represent the Medical Faculty in the Senate. Dr. Barnes was one of the first to originate the Graduates' Association, which ultimately led to the new charter creating Convocation, and he has been an examiner in the University, where he graduated M.D. in 1848. Dr. Buchanan's name is equally well known, and his present position of Medical Officer of the Local Government Board is ample testimony to an administrative ability and special knowledge which will be of great service in the deliberations of the Senate. He has always taken an active part in Convocation, and has long been a member of the Annual Committee. He graduated M.D. in 1856, and B.A. in 1851. Our contemporary, the *Spectator*, which is always well-informed on matters concerning the University of London, supports the candidature of Dr. Buchanan, of whom it says that "he is known to be an admirable administrator, and has that charm of manner which adds indefinitely to the personal influence of learned and sagacious men."

ANATOMY OF PANIC.

THE phrase "the anatomy of melancholy" amply justifies "the anatomy of panic." The mental state designated panic is, psychologically, a paralysing perception of peril. The power of self-control is suspended. The judgment cannot inhibit impulsive or emotional acts. The processes of reason—in its higher manifestation—are in abeyance. Panic spreads from one individual to another, as well as affects many in common. The same impression which is produced on one sensorium may be produced on any number simultaneously by the primary cause of fear; but there is nothing else so calculated to produce panic as the evidence of panic in the mind of another person, especially one or many with whom the mind impressed—in this secondary way—may chance to be in habitual or occasional sympathetic relation. It matters little to the general result whether the impression be produced or extended through the sense of sight or hearing, or even general sensation. It is sufficient that it can be produced and propagated in either of several ways. The true remedy for panic must be, in great part, preventive. It is a capital suggestion that a permanent notice which all can read should be displayed across curtain and act drop "writ large" and plainly stating the time in which the auditorium of a theatre can be emptied if only the audience will individually determine to keep their wits about them, and stating the number and location of the places of exit. Again, the manager and chief performers at a theatre should make it a point of honour to keep *their* self-possession, and preserve smiling faces above the footlights if any hitch occurs. It is useless to speak or shout; nothing can so rapidly reassure a theatrical audience in panic as the sight of a self-possessed and smiling face instantly presented on the *stage*. One man may do more in this way than can be done by half-a-dozen in any other. Another point of moment is to impress the mind through the ear. Let the orchestra instantly strike up a cheerful tune. We heard the other day how an organist saved hundreds from panic in a church by playing a tune which instinctively brought the audience on their knees. On the same principle the orchestra in a theatre should call the panic-stricken spectators back to their seats by a bright burst of music. Surely managers and conductors might contrive these "effects" and train a few faithful fol-

lowers to support them. Another matter of the highest practical moment is to make the ways of exit ways of common ingress. It is impossible to lay too great stress on this obvious precaution. It is worth while to study panics at leisure, and devise means for their prevention or prompt arrest.

THE USE AND DANGERS OF IODOFORM.

THE value of iodoform as an external application in venereal and syphilitic affections has led Dr. Thomann of Graz to test its value in subcutaneous injection. He employed a dilution of six parts of iodoform to twenty of glycerine, and also a solution in almond oil. He commenced with doses of ·3 gramme, gradually increasing the quantity to ·75 gramme. In cases of early constitutional syphilis the symptoms rapidly subsided after ten or twelve injections in various parts of the body. No local suppuration was produced. A little pain was sometimes caused, which soon passed away. Rather more reaction followed the solution in oil, especially if the latter was not freshly prepared. An excretion of iodine by the urine could be demonstrated in the first two days after the injection, but no odour of iodoform could be perceived in the expired air, perspiration, or urine. The general health was not disturbed, and the dose employed had no narcotic action, and no effect on the temperature or pulse. Since iodoform is coming into increased use, it is well that the occasional occurrence of unpleasant symptoms from its employment should be known. Oberländer, some years ago, described a case in which a woman had taken forty-two grammes of iodoform in eighty days, and then had a sudden attack of giddiness, weakness in the legs, and double vision, followed by a period of excitement, interrupted by broken sleep, with headache, sensations of impending death, constant convulsive movements, and irregular respiration. After improvement, the resumption of the iodoform was at once followed by a relapse. In a recent paper in the *Allgemeine Wiener Med. Zeitschrift* two cases in which an eruption was the apparent consequence of the external use of iodoform have been recorded by Zeissl. An ulcer on the leg of a boy three years of age was dressed with iodoform, the dressing being several times changed in the course of a fortnight. At the end of that time the temperature suddenly rose to 105°, and a diffuse erythematous eruption appeared on the flexor aspect of the upper part of each arm and the inner side of each thigh. The affected areas were bright red in colour, the intermediate parts of the skin being normal. The child was somnolent and vomited some greenish-yellow masses. On the third day after the removal of the iodoform the temperature became normal, and the exanthem gradually faded. During its existence the urine gave a distinct iodine reaction and contained some albumen and renal epithelium. The applications of iodoform being resumed, another attack occurred precisely similar, attended with the same elevation of temperature and albuminuria, disappearing five days after the cessation of the iodoform dressing. Ultimately, however, tolerance of the iodoform was established. In another case iodoform was applied to a fistula connected with carious bone. After a week the patient was attacked with an eruption like urticaria, sharply circumscribed prominent red spots surrounded by reddened skin. Some of the raised spots had a diameter of two centimetres. They were especially abundant on the flexor aspects of the limbs. The urine contained no albumen. The application of iodoform was discontinued, and the eruption subsided in the course of a week. With regard to the occurrence of albumen in the urine in the first case, Zeissl remarks that iodine in toxic doses has before been known to cause albuminuria; and that it is desirable always to watch the urine in cases in which iodoform is applied as a surgical dressing.

AMERICAN EDITIONS OF ENGLISH MEDICAL BOOKS.

WE have so often protested against the disgraceful practice of pirating English medical books by American publishers and editors, that we are in justice bound to reproduce the severe censures on the custom contained in the *Philadelphia Medical Times*, edited by Dr. Horatio C. Wood, in its issue for December 17th. We welcome this outspoken condemnation as representing the opinion of one of the best of our Transatlantic *confrères*. After referring to a previous notice of the American edition of the "System of Surgery," edited by Mr. Timothy Holmes, our contemporary says:—

"The system of publishing English medical works, which has grown up in this country, is nothing more or less than legalised buccaneering: it is appropriating other people's property by sanction of law, and giving them no return therefor. Its practice by men whose lives are otherwise honourable is a marked instance of the weakness of human nature, and of the necessity of law as a trainer of human conscience. Almost always in these cases the editor is the cat's-paw; and it is very curious that medical men—the writer of this in his early days among them—allow themselves so to be used, apparently without perceiving that they are being burned. These editors are underpaid,—usually with a miserable pittance flung to them,—are in most cases men of upright intentions, but are simply without thought following in the footsteps of their predecessors. Is it not time that someone should put this matter in its true light? Is it not right that we medical writers all should understand exactly how we are being used by publishers, and how we are unwittingly at the same time injuring our colleagues across the water, and our own higher professional interests in this country? Men will not write medical books unless there is a prospect of success; and how can success be achieved by a book loaded with a copyright pitted against one stolen from English brain, and having, therefore, only one profit to pay? We regret very much that this discussion should seem to centre upon the editors of Holmes's Surgery, as they are a body of honourable men who have had very low wages for conscientious work, who have been following simply in the line of old custom, and who, if they had seen the matter in the light we see it, would, we believe, never have been editors of the book. Being ourselves in this matter not without sin, we desire to cast no stone; but the discussion has to turn upon some pivot, and we hope it will now go on and widen until the whole profession appreciates the fact that a good name is not to be connected with such a transaction, and publishers become unable to get foremost men of the profession to prepare English books for the American market unless a fair compensation is paid to the original author."

Among the members of a learned and honourable profession common honesty and international courtesy should not, in these days, be quite unattainable.

HEROIC BOTANISM.

AN inquest was held by Mr. Sheffield, coroner, a few days ago, showing the contest that a little child, eleven months old, among the unintelligent, may have to go through between disease and a botanist's treatment. The parents, when the child was taken ill, gave some syrup of violets and oil of almonds, and afterwards some castor oil. The child being worse, they sent for Thomas Garbutt, who called himself a "medical botanist." He prescribed successively castor oil, nitre, a warm bath for ten minutes, where she was to have medicine every five minutes; four subsequent baths, during and after which the medicine was administered, which contained camphor, lobelia, peppermint, and syrup. The child still, and very naturally, becoming worse, was taken to Garbutt's premises, in which was a Turkish

bath. After giving an injection, the little patient was put into a hot [room at 120°, where it] died. Both the parent and the botanist declaring that they had no religious belief, the coroner refused to take their evidence. Mr. Thomas Stewart said that at the post-mortem he found congestion of the brain and bronchitis. The jury passed a corresponding verdict, and censured the parents for their action, and further stated that "the conduct of Thomas Garbutt is greatly reprehensible in treating deceased as a medical man, which treatment, in the opinion of the said jurors, may have accelerated the death of the deceased." The reflections of the jury are very just, but they are not likely to be of much avail while our laws permit such cruel neglect of the sick and such excesses of liberty on the part of unqualified men.

PATHOLOGICAL SOCIETY OF LONDON.

THE annual meeting of this Society was held on Tuesday last, and the list of officers nominated by the Council elected. The report of the Council was very satisfactory, and showed that thirty-one new members had joined during the past year while sixteen had been lost by death or retirement. Special reference was made to the loss the Society had sustained by the death of Mr. Crucknell, Dr. Rolleston, Vogel, and Pirogoff. The Council has had under consideration two proposals made by Mr. Hutchinson, and as a result has appointed a committee of the Society to examine all the Transactions of the Society and obtain and publish further notes of the incompleted cases. Being deeply impressed with the importance of the study of comparative pathology, the Council has resolved on establishing a standing committee for the purpose of obtaining, exhibiting, and reporting on specimens of diseases and injuries in the lower animals, and especially to make use of the material available at the Zoological Gardens, which has been placed at the disposal of the Pathological Society by the Zoological Society. Drs. Creighton, Heneage Gibbes, Klein, Payne, Warner, and Mr. Shattock are the members of this committee, and Mr. Sutton and Mr. Hutchinson, junior, are working with this committee and are in frequent attendance at the post-mortem examinations of animals at the Zoological Gardens. This is a most important step, and it is to be hoped that soon much further light will be thrown on some diseases of man. Dr. Coupland has been elected on the Morbid Growths Committee in place of Dr. Greenfield. The treasurer's report showed an income of £550 9s. and an expenditure of £537 2s. 9d., the balance in the hands of the treasurer being in slight excess over that of last year. The adoption of the report was moved and seconded by Drs. Kesteven and Crocker, and carried; and a resolution thanking the retiring vice-presidents and members of council was moved by Mr. Bryant, who remarked that the Pathological Society worked with less friction than any other Society in London; the resolution was seconded by Dr. Cholmeley, and carried unanimously, and Dr. Barlow acknowledged it in the name of the retiring officers.

THE REDUCING POWER OF PROTOPLASM.

AN observation of Löw and Bokorny, which finds in the power of reducing minute quantities of a metallic salt a distinction between living and dead protoplasm, is also of interest as affording an explanation of the mode in which staining from silver salts occurs in Argyria. Several kinds of fresh-water algæ are found to have the power of separating metallic silver from an alkaline solution, while the effect is not produced by dead algæ. The solution employed contained one part of nitrate of silver in 100,000 of water, with a small quantity of potash and ammonia. The same action was obtained, however, when the silver solution was ten or twenty times more dilute. Among chemical substances which reduce silver, aldehyde and benzoldehyd act on a solution of 1 in 100,000; but pyrogallic acid and hydrochinon act only on a solution of 1 in 12,000, and formic acid only on 1 in 1000. On a solution of one part of silver nitrate in one million parts of water no known chemical substance has any action. Two filamentous algæ were employed for the experiment, spyrogyra and zygnema, which were cultivated in brook-water, to which some nitrate of ammonia and phosphate of potash had been added. A chemical analysis of algæ thus cultivated and afterwards dried, showed that they consisted of 2·806 per cent. albumen, ·010 fat (with lethicin and chlorophyll), ·111 glucose, 6·077 starch, cellulose, and vegetable mucus, ·009 ash and 90·387 water. Such living algæ placed in the dilute silver solution show in a few hours distinct darkening of the fibres, and in twelve hours the protoplasm of many cells is black from reduced silver; very few remain colourless. The colouration is deepest at those parts which are the seat of the most active vital changes, especially at the ends of the cylinders of protoplasm, so that the segments are separated by black transverse striæ. If, however, the algæ are warmed to 50° Centigrade for five minutes their power of reducing silver is permanently arrested, and a similar effect is produced by immersion in a one per cent. solution of sulphate of copper, sulphuric acid, caustic soda, or by an hour's exposure to the vapour of ether. On the other hand, the action is not prevented by immersion in an aqueous solution of veratrin, or a ·2 per cent. solution of acetate of quinine. The same reduction of silver is effected by the hairs of many plants, and by the roots and stalks of phaneorgams. Only negative results were obtained with the spores of fungi and yeast buds. The investigators are of the opinion that the reducing power of living albuminous protoplasm depends on the presence of substances of the nature of aldehyde, which are altered during the act of death by redistribution of the atoms into new molecules.

COMPLAINT AGAINST HOSPITALS.

THERE is abroad a tendency to be hard on hospitals. The last illustration of this is found in an inquest before Mr. Langham on December 28th at St. Martin's Vestry Hall, touching the death of Mrs. Harriett Hyatt, the wife of a builder, who was admitted to hospital with compound fracture of the right thigh. Mr. Hyatt objected to send his wife to a hospital, having a great aversion to hospital treatment. But his objections were overcome. He had no complaint to make of the treatment his wife received, but he found cause of complaint in the time at which the unfavourable symptoms in his wife's case were reported to him, insisting that these symptoms were noticed by his wife a day previous to that in the account of the house-surgeon. This is really pushing criticism too far. Considering Mr. Hyatt's station and the accommodation his wife received in distressing circumstances, we think a hearty note of gratitude, accompanied, perhaps, by a cheque to the treasurer of the hospital, would have been a more appropriate course.

ACTION FOR MEDICAL ATTENDANCE.

MR. JUSTICE DENMAN, in the Queen's Bench Division, in the case of Butcher *v.* Hopkins, an action for medical attendance on a boy against his master, recently gave an important judgment in favour of the plaintiff, confirming a previous judgment in the Salford County Court. The boy was accidentally injured in the defendant's bleach works. The defendant was absent, but his bookkeeper wrote a note to the doctor asking him to attend the boy, and signing thus, "Yours for the company, Wm. Vernon." The defendant on coming to the works was informed of what had been done. In the course of the case it was pointed out that the

bookkeeper had not power to sign for the defendant. Nevertheless the judge decided for the plaintiff on the ground that the bookkeeper, in the absence of the defendant, was the natural person to act for him, and his acts, if reasonable, were likely to be ratified by him. Clearly, if the defendant did not intend to ratify his bookkeeper's acts, he should have said so to the doctor. It is very easy to have a *locum tenens* to hand accidents over to a medical man and then repudiate liability. But it is very hard on the doctor. And we hope Mr. Justice Denman's judgment will be some protection to the profession.

RECURRING LETHARGY.

AT the Hospice-Général at Rouen a remarkable case of lethargy is to be seen at the present time. For twenty days a woman, thirty-seven years old, has been in a profound sleep, which is broken for a few moments each night, when she takes some food. The sleep is accompanied by general rigidity, so that the whole frame can be raised as one piece. Her first attack was fourteen years ago, and periods of lethargy have recurred since from time to time. During the intervals she seems perfectly well, and has been employed at the hospital as nurse. Just before the onset of an attack she becomes nervous and taciturn. The onset is always sudden; she goes to sleep in a moment, whatever she may be doing. During the lethargic state the face is well coloured and warm, and respiration is regular, but there is, as stated, general muscular rigidity. About half-past ten each night the legs begin to tremble, slight groans are uttered, and are precursors of the brief nocturnal remission. At eleven o'clock she opens her eyes, sits up and eats what is given to her without speaking. Then she again puts her head on the pillow and goes to sleep, but the limbs are relaxed until about four o'clock in the morning, when the rigidity again comes on, and lasts until the following night. Twice she has slept continuously for ninety-six hours without taking food. She does not lose flesh. The long period during which these attacks have recurred, and the form of fixed, not cataleptic, rigidity, render the case unusual, even among the rare instances of lethargic trance.

UNIVERSITY COLLEGE, LIVERPOOL.

THE ceremony in connexion with the opening of this institution is fixed for Saturday, the 14th inst., at St. George's Hall. The Earl of Derby will preside on the occasion, and the Principal (Professor Rendall) will deliver an inaugural address. The lectures and classes will commence on Monday, January 23rd. The following is a list of Professors in the Medical Faculty:—Medicine, A. T. Houghton Waters, M.D., F.R.C.P.; Surgery, Rushton Parker, B.S., F.R.C.S.; Anatomy, W. Mitchell Banks, M.D., F.R.C.S.; Physiology, Richard Caton, M.D., M.R.C.P.

SUPPRESSION OF INFECTIOUS DISEASE.

MR. SERGEANT, the medical officer of health for Bolton, has published in a pamphlet form an account of his experience of the operation of the Bolton Improvement Act of 1876, particularly in so far as it relates to the notification of infectious disease. This Act was approved by a Parliamentary Committee, notwithstanding that it was asked for by a corporation which had notoriously failed to carry out the measures which it was empowered to execute under the Public Health Act of 1875, particularly as to hospital provision. Failing this important matter, Mr. Sergeant is of opinion that the operation of the notification clause of the Act has been in every way beneficial. It has given very precise direction to the efforts in regard to general sanitary measures and disinfection displayed by the medical officer of health and his staff, and enabled a quantity of definite sanitary work to be done which could not otherwise have been effected. Mr. Sergeant sees this in the following figures he produces:—

	Average Annual Mortality.		
	1867–1876.		1877–1881
Small-pox	12	...	·4
Fever { Typhus / Typhoid / Continued Fever } ...	54	...	35·2
Scarlet Fever	104	...	85·8
Total average ...	56·6	...	40·4

Estimated population of Bolton in 1876, 94,300
Population of Bolton at last census ... 105,414

We shall look for Mr. Sergeant's further experience with much interest.

THE RISKS OF INTRA-PLEURAL INJECTIONS.

A FEW years ago we heard far more frequently of fatal accidents occurring during the operation of washing out an empyema than we have of late; but we are reminded of these risks in a note from Professor Billroth's clinic in the *Allgemeine Wiener Med. Zeitung* for Dec. 20th. The writer says that Professor Billroth has become convinced of the inutility of injections for the purpose of washing out the empyemic cavity, except in the case of blood-clots and decomposing secretion; and in the latter case it suffices to perform a single but thorough injection. Thus in one case of a shot-wound in the left thorax, leading to putrid empyema, Professor Billroth made a counter-opening, and for four days allowed thymol to flow through. In ordinary empyema the chances are favourable when the operation is done at the right time, for the longer pus remains in the thorax the longer the lung keeps atelectatic, and thus does not approach the wall of the thorax. A rib is resected, a drainage-tube introduced, and pus allowed free escape—a method of treatment much like that practised by Hippocrates, who bored through the rib and introduced a short smooth metal tube into the opening. To diminish pus formation a rod of iodoform can be placed in the pus cavity. Injections of cold disinfecting fluids often lead to ill consequences. Professor Billroth relates one—a female, twenty years old, with empyema, who was treated by means of injections. One day, when a cure was nearly accomplished, she became unconscious during the injection, and could not be restored. Dr. Wölfler also had an older patient who became unconscious during the injection, but who recovered. Billroth explains these remarkable phenomena, that a shock is received by the organism, excited through the peripheral nerves by means of cold water, and under ever so slight conditions, it may be the cause of death; just as a mere blow on the testicle or stomach region can be fatal. Therefore it is important to employ injections, when they appear necessary, of warm fluid.

FOREIGN CHEESE.

EVERYONE must have noticed the great increase which has taken place of late years in the consumption of foreign cheese in England. Gruyère, Camembert, Roquefort, and Gorgonzola, not to speak of Bondon, Brie, and Parmesan, which a few years ago were hardly known in this country, are now to be found in thousands of houses and in almost all hotels. We are inclined to think that this apparent alteration in public taste is due in part to a deterioration in the quality of English cheese. American cheese of good though ordinary quality has come over in enormous quantities, and can be sold at a low price. The English makers seem to have been discouraged by this competition, and instead of endeavouring to raise the quality of their goods, they have fallen back on the never-failing demand for milk,

and have stopped or diminished the manufacture of cheese, and, what is worse, have become careless in its manufacture. Cheese imported from abroad is almost invariably good, and offers a great variety of delicate flavours. The makers of some of the best kinds are able to produce that much-prized green mould formerly so often and now so seldom seen in English cheese. Even Stilton seems to us to be harder and drier than it used to be. Surely careful study would teach English makers to keep up with their continental rivals, and so preserve to this country a manufacture which was formerly so important and lucrative. They probably could not compete with the Americans and Dutch in the commoner makes, but they might surely rival other countries in the production of the finer kinds.

THE BIRKENHEAD IMPROVEMENT ACT, 1881.

IN July last the Royal assent was given to an Improvement Act for Birkenhead, which among other matters included provisions for the notification of serious infectious diseases by medical men, for providing houses of refuge for members of families in which infectious diseases had appeared, for providing nurses for the sick, for closing schools in which dangerous infectious disease had appeared, and for closing dairies, shops, &c., in which there was reason to believe any infected article was being sold. This Act was to come into force on the first day of the present year. On the Sanitary Authority taking the preliminary measures to put the Act in force, we learn that a meeting of the medical profession in Birkenhead has been called for the purpose of protesting against its provisions, so far as these relate to the notification of disease. Evidently the evil example of Liverpool in this matter has extended to Birkenhead, and a protest is to be made, late though it be. This protest is clearly an afterthought.

"BURGLARS AND ANÆSTHETICS."

THE recourse to chloroform by burglars may be an advance on the use of the jemmy, but the anæsthetic is scarcely likely to be skilfully or safely administered by Bill Sykes—therefore it is necessary to protest against the innovation. We will not hastily jump to the conclusion that the device has actually been adopted. The mere fact of waking with pains in the head in the morning following a Christmas Eve is not final proof of the fact that an anæsthetic has been administered. However that may be, we venture to think the arrangements of any house must be defective into which a burglar can enter in such leisurely fashion as to be able to obtain access to a bedroom, and quietly place two persons in a state of unconsciousness by the use of an anæsthetic before he proceeds to ransack the premises! Surely precaution may easily be taken against such an intrusion.

ADIPOCIRE.

ADIPOCIRE, according to Professor Ludwig, is often met with in bodies buried in German churchyards in clayey and very damp soils. It is not uncommon to meet with bodies that have undergone a complete waxy transformation. Gravediggers often take pounds of the substance to chemists and offer it for sale as "spermaceti," and it is held in considerable popular estimation as a therapeutic agent, being given internally as a diaphoretic. Chemically it consists of a mixture of several fatty acids combined with lime and ammonia. A specimen lately analysed in Ludwig's laboratory was found to consist of oleic and palmitic acids, and another specimen contained several free acids and a lime soap. The latter is only present when the body has been buried in calcareous soil, and is absent in the adipocire found in bodies which have been long in water, as well as in the adipocire of the maceration jar. Various opinions have been held as to the manner in which the fat is formed. Some assert that merely preformed fat, already existing in the animal body, becomes saponified. Others believe that, in addition to this origin, another source is a transformation of albuminous material. Ludwig described a series of original investigations which led him to accept the latter view. The adipocire comes partly from the normal fat of the organism, which is slowly decomposed by the acid products of decomposition. Under certain circumstances, however, nitrogenous substances may undergo such decomposition as to furnish small quantities of fatty acids, strange as such an occurrence may appear from a chemical point of view. A period of at least six months is required for the formation of adipocire.

PUBLIC VACCINATION IN DEMERARA.

THE medical profession in Demerara, at least those members of it who act as public vaccinators, appears to have come into collision with the Colonial Government on a question of the position of vaccination stations. A rearrangement of these stations, which the vaccinators were called upon to make, gave rise to observations among members of the Legislature as to the want of consideration and judgment shown in several instances. It was averred, indeed, that in these stations the convenience of the medical man had been regarded, and not of the person to be vaccinated or brought for vaccination—vaccination being compulsory in the colony. Under the circumstances of the case, the Government asked for an explanation of the conditions which had governed the selection of the stations, and several medical men were ill-advised enough to reply to the request of the Government by answers which must be characterised as impertinent, and generally to resent the interference of the Government in the matter. It would be difficult to justify an attitude of this sort in what is really a public question of much importance, and we trust that the irritation arising out of it has already passed away.

THE ORANGE-PEEL NUISANCE.

THE scattering of orange-peel on pavements is much worse than a nuisance, it is a source of peril to limb and even life. The police authorities have issued a circular warning the public against the practice of dropping pieces of this slippery rind on the foot-paths. Why do they not go a step further and instruct constables to take the trouble to kick these droppings off the pavements? The men have little to occupy their minds, and look very miserable on their rounds, when they are not either gossiping or chasing the poor little boys who sell newspapers or matches. It would afford them a little harmless and useful amusement to do as we suggest. As it is, those of us who are at all careful find it necessary to stop even when in haste to remove the peril. This is easily done, but the police might do it better than the public; and if they did, the fact would deter careless folk from dropping orange-peel, particularly if constables were instructed to caution offenders.

COLONIAL MEDICAL OFFICERS.

WE learn from the *Colonist* that the medical profession in Demerara are about to form a medical society, and that a petition has been drafted to the governor praying that the salaries of the Government medical officers may not be reduced, a step believed to be in contemplation. Our contemporary protests against the inadvisability of this course, having regard to the duties which the medical officers have to perform, and expresses a hope that the proposed medical society will have the result of bringing the medical profession in the colony into more cordial relations among themselves.

THE RAPIDITY OF ABSORPTION FROM WOUNDS.

SOME observations on the rapidity of absorption from wounds have been communicated by M. Davaine to the Académie des Sciences. The question is one of great practical importance, since a virus so often enters the system by this means. That absorption from a subcutaneous wound is extremely rapid has been demonstrated, the *Gazette Médicale* reminds us, by the experiments of Renault on the poison of glanders, and by those of Colin on that of anthrax. A few minutes were found to be sufficient, so that cauterisation was useless if it was performed more than ten or fifteen minutes after the inoculation. The investigation of Davaine related to the important question whether absorption is equally rapid from the surface of all wounds, and he concludes that it is not. Having placed material from a case of anthrax on the surface of wounds produced in rabbits by vesicants, friction with rough surfaces, or the removal of a small piece of skin, he found that many animals survived when the wound was cauterised with potassa fusa one, two, or three hours afterwards. He suggests an anatomical explanation of the difference in the experimental results. In a subepidermic wound a number of small vessels are divided and the circulation is maintained by the collateral branches which are given off immediately below the divided vessel, and by this the poison, which has penetrated into the interior of a divided vessel, is carried into the general circulation. The same effect is not produced in a more extensive wound, probably because most of the vascular trunks are divided. Whatever be the explanation, it is clear that punctured wounds are by far the most dangerous, and that cauterisation to be effective should be very prompt.

FEES FOR MEDICAL EVIDENCE GIVEN BEFORE MAGISTRATES.

THE *Surrey Advertiser* reports a case in which a medical practitioner giving evidence in criminal proceedings taken before a bench of magistrates was referred to the prosecutor for his fee. This opens up a wide question of liability, into the discussion of which we will not at present presume to enter. Meanwhile suffice it to warn medical practitioners against the folly of attending courts of justice, or doing any service whatever at the request of public authorities, without the reception of a legal summons or warrant. It is perfectly vain to look for justice or fair dealing at the hands of boards or officials of any class. If medical services are required, they must be formally asked for and then rigorously compensated. This is the only safe principle on which to proceed.

NATIONAL REFUGES.

THE Committee of the "National Refuges" are making a special appeal for help to enable them to carry on the beneficial work of the training ships *Chichester* and *Arethusa*, where a thousand children are maintained. In connexion with the same benevolent enterprise there are also a home at Twickenham, two farms at Bisley, Surrey, two homes for girls at Ealing and Sudbury. We heartily commend the claims of this institution to the notice of our readers and through them to the public. There is no better service to the State and community than that which helps to rescue poor children from lives of neglect, certain to end in pauperism or crime, and strives to make good, healthy, and useful members of society. Mr. Alfred George Sharpe, of the Stock Exchange and 33, Brompton-crescent, who makes the present appeal, has our best wishes for success in his praiseworthy undertaking.

ABUSE OF PROVIDENT DISPENSARIES IN MANCHESTER.

A VERY animated discussion of this subject is going on in the Manchester papers. We see no allusion to one of the grossest charges—the wholesale canvassing of the patients of medical men. Associations are surely not wanted to disturb existing and creditable arrangements between medical men and their private patients or friendly societies. Such interference is utterly uncalled for and unjustifiable.

FROM the *Publishers' Circular*, issued by Messrs. Sampson Low and Co., we learn that the number of books published last year was less by 300 than in 1880. This decrease is attributed by the statisticians to the enormous development of the periodical press. The total number of new volumes (including new editions) amounted last year to 5406. These are divided into fourteen sections. The lion's share falls to the first section—viz., Theology, Sermons, &c. (945); whilst to the fifth—Law, Jurisprudence, &c.—is allotted the smallest number of new works (133). Medicine, Surgery, &c.—the twelfth section—stands low in the record, 164 new books, of which 56 were new editions, having been added to medical literature during 1881. In the previous year the number was 202, 54 of these being new editions.

BY permission of the Post-office authorities, a small station under the auspices of the St. John Ambulance Association has been established at the General Post-office. A stretcher, splints, tourniquet, roller and triangular bandages, lint, and other useful *matériel*, in a weather-tight case, will be kept in readiness for immediate use in case of emergency. A member of the Association's medical staff has generously offered to defray the cost of the above. It is intended, if funds permit, to establish other similar stations wherever possible. Numerous classes are being formed at Cannes and Nice.

BY telegraph the intelligence has been received of the death of Dr. Draper, of New York, at the age of seventy-one. Dr. Draper was a native of England, and, after studying in London, proceeded to Philadelphia, where he graduated in 1836. He became Professor of Chemistry and Natural History in the University of New York, and was afterwards appointed President of the Scientific and Medical Departments of the University. Dr. Draper was a prolific writer on scientific subjects.

THE number of candidates who presented themselves at the several examinations for the licence of the Royal College of Physicians of London during the year 1881, and the number of those who were approved, are as follows:—

	Candidates.	Approved.
First Examination	367	258
Second ,, ...	46	20
Third, or Final ,, ...	116	90

THE Lettsomian Lectures for the present session will be delivered by Mr. Royes Bell, F.R.C.S., at the rooms of the Medical Society of London, Chandos-street Cavendish-square, on Jan. 9th and 23rd, and Feb. 6th—each lecture commencing at 8.30 P.M. The subject chosen for the series is, "Diseases of the Testicles and their Coverings."

DR. MACLEOD, who for several years has acted as assistant Medical Superintendent at Garlands Asylum, where his services were highly appreciated by the authorities and patients, was on the 2nd January unanimously appointed Medical Superintendent of the East Riding Asylum, Yorkshire.

THE Act to Consolidate the Alkali Acts of 1863 and 1874, and "to make further provision for regulating alkali and certain other works in which noxious or offensive gases are evolved" (44 & 45 Vict., cap. 37), comes into operation with the new year.

KING HUMBERT has conferred upon Sir William Mac Cormac, F.R.C.S. Eng., the Crossand Collar of Knight Commander of the Crown of Italy, in recognition of his distinguished scientific attainments.

MR. W. F. TEEVAN, B.A., F.R.C.S., has been elected President of the West Kent Medico-Chirurgical Society, and Honorary Member of the Medical Society of the State of New York.

A COMMITTEE has been formed to promote the raising of a testimonial to Mr. Alfred Baker, late honorary surgeon to the General Hospital, Birmingham, in recognition of his long and valuable services to the institution.

THE death is announced of Dr. Brierre de Boismont, at the age of eighty-three.

Public Health and Poor Law.

LOCAL GOVERNMENT DEPARTMENT.

REPORTS OF MEDICAL OFFICERS OF HEALTH.

Salford.—Dr. Tatham comparing the earlier years with the later years of the past decennium, that is to say, the years during which Salford has had the advantage of an infectious disease hospital—viz., since 1876—finds that in the earlier periods (1871–76) the mortality of the borough was equal to 28·5 per 1000 of the population, while in the later period (1877–80) it was equal to 27·0, thus showing a reduction of mortality in the more recent period equal to 5·4 per cent. Any indication of improved and improving healthiness in Salford must be welcomed, for the difficulties encountered in controlling the sources of unwholesomeness in the borough are very many and such as to test to the uttermost the skill and patience of its sanitary staff. Dr. Tatham comments on the atmospheric impurity existing in the borough partly from organic contamination, the result of overcrowding, and to be reached only by wholesale demolition of property, a measure not open to practical consideration; and partly from the contamination of smoke from factory chimneys, a matter admitting of very definite improvement, but in which, unhappily, the sanitary authority, at its gas works, is one of the worst offenders. No less than 212 persons died without medical aid during 1880. "The treatment of the sick poor at their own homes," he says, "is in its very nature a measure of preventive medicine, for the administration of which the antiquated and cumbrous machinery of the Poor-law is utterly unsuited. If instead of being, as at present, the officers of the guardians, the Poor-law medical staff were in relation with the sanitary authority, their intimate acquaintance with the habits and dwellings of the poor would in that case make them especially valuable agents in the prevention of the disease." Dr. Tatham has some observations on infantile neglect resulting from female factory labour. Salford is high in the scale of those towns which suffer from large infantile mortality, and he sees little hope of stemming this high rate, except in the gradual extension of a better class of education to the mothers—a question of the future—and the establishment of day-nurseries. The experiment of a day-nursery, he tells us, is about to be tried at Pendleton, a suburb of Salford. Salford adheres to her middens and her midden-system with a tenacity worthy of a better cause. The sanitary authority itself deliberately retains within the precincts of the borough, and in the immediate vicinity of occupied houses, the filthiest and most unwholesome of all the refuse of a community. Many years have been wasted in considering this question, and the simple solution of removing the filth at frequent intervals has been rejected until some impossible system of dealing with it has been devised. Meanwhile the people sicken and die. The special feature of disease prevalence in 1880 was an outbreak of typhus in the borough. The disease was confined to four localities, and in the greater number of the patients the cases were connected with each other. The outbreak occurred under conditions described by Dr. Tatham as follows:—"It is difficult to give a description in words which shall convey to a stranger an adequate idea of the manner in which these poor people pass their lives. They are so irregular and migratory in their habits that they cannot be said to have any settled residence. Crouched up in the corner of rooms for warmth, with nothing better for a bed than straw, or filthy flocks, these poor wretches lay half-naked on the floor, in a condition piteous to behold. For the most part there seemed to be no distinction of sex or even of family as regards their distribution in the sleeping rooms. Husbands and wives, lodgers and tenants of both sexes, lay huddled together in a common litter in a state of filth which may truthfully be described as bestial. Under circumstances like these there is little wonder that the poor creatures fall an easy prey to typhus, or that when once the disease has obtained a foothold among them it spread with such alarming rapidity." The outbreak which lasted throughout the year and extended into the spring of 1881 resulted in 104 cases, with a mortality of 23 per cent. Dr. Tatham's account of it deserves perusal, and he speaks in the highest terms of the assistance, "unselfish and fearless," he derived from his sanitary inspectors in dealing with it.

Leeds.—Dr. Goldie's report on the health of Leeds during the month of November, 1880, shows a reduction of mortality over the corresponding month of the previous year; and shows, also, that the health of the borough compares most favourably with any of the large towns in England and Scotland.

THE TOWN LABOURERS' DWELLINGS ACTS.

Dr. Cameron, the medical officer of health for Dublin, has published a paper on the results of the Town Labourers' Dwellings Acts, originally read before the Dublin Congress of the National Association for the promotion of Social Science. He addressed in September of last year a circular letter to the municipal authorities of every town of 20,000 inhabitants or upwards in the United Kingdom, asking for information as to the erection of dwellings for the labouring classes, either by the local authorities or by companies or individuals. Answers were received from seventy-six, and he observes: "In comparatively few instances have the Acts enabling local authorities or private persons to erect dwellings for labourers in towns been put into force." Giving briefly the result of the application of these Acts in various towns, Dr. Cameron next examines the question of their applicability to Dublin. He describes the lamentable deficiency of labourers' dwellings in Dublin, and the extent to which this deficiency is being increased from year to year by the closure on the part of the sanitary authority of dwellings unfit for habitation. "The closing of tenements unfit for habitation is now a daily occurrence, and the evicted persons are complaining, and with justice, that they cannot find proper habitations unless at much higher rates than they can afford to pay. ..... Since September 1st, 1879, up to Aug. 31st, 1881, 799 houses, 240 cellar dwellings, and 150 rooms unfit for human habitation were detenemented and closed, nearly altogether on my evidence as to their unfitness." Dr. Cameron would here have the sanitary authority step in and, exercising the ample powers given to it by statute, erect houses to meet the wants of labourers in the city. He believes this could be done at a rental which would not entail a burden on the city, and at the same time meet the necessity for the low rental which exists among labourers.

AN ANTI-VACCINATION DEMONSTRATION AT DEWSBURY.

The anti-vaccinationists at Dewsbury recently organised a demonstration against the vaccination officer, Mr. J. T. Marriott, of Batley. Two brass bands, torch bearers, sensational pictures, and an effigy of the obnoxious official had part in the demonstration. Mr. Marriott was one of the most amused of the spectators.

The Local Government Board, it would appear, has addressed a communication to the Stoke-on-Trent Town Council on the subject of the smoke-nuisance in the suburb of Basford. The Board has expressed the opinion that the Town Council have neglected their duty, and call upon them to decide within three months a measure for the enforcement of the Act.

The Rural Sanitary Authority of Guildford have addressed a letter to the Local Government Board, urging upon the Board to take into early consideration the propriety of bringing before the House of Commons a measure providing for the immediate notification to the Sanitary Authority of infectious diseases within its district.

Among the several addresses delivered at the Brighton Health Congress, very noteworthy was an address by Dr. N. P. B. Taaffe, medical officer of health for the town, "On the Propagation of Disease, &c., through the Media of Food and Drink."

We understand that it has not been found practicable to take legal measures against the gipsies encamped on the Greenwich marshes, and amongst whom a case of small-pox was recently found.

A milk-dealer has been recently fined in the Huddersfield Police-court for the removal of fatty matter from, and the addition of water to, milk supplied by him.

A man was recently fined at Greenwich for leaving the house and also attending to the door while convalescent—in the *scabbing* stage—of small-pox.

VITAL STATISTICS.

HEALTH OF ENGLISH TOWNS.

Under the influence of the five cold days ending on the 25th ult. urban mortality showed a marked increase. In the twenty large English towns dealt with in the Registrar General's weekly return, 4725 births and 3976 deaths were registered in the week ending Saturday, 31st ult. The annual death-rate in these towns, which had slowly increased from 20·6 to 24·1 in the four preceding weeks, further rose last week to 27·3. The lowest rates in these towns last week were 16·9 in Bristol, 17·8 in Norwich, and 20·1 in Plymouth; the rates in the other towns ranged upwards to 29·8 in Manchester, 30·1 in Leicester, 31·9 in Liverpool, and 22·2 in Nottingham. The deaths referred to the principal zymotic diseases in these towns further rose last week to 596, and included 181 from whooping-cough, 134 from measles, 126 from scarlet fever, 45 from "fever" (principally enteric), 42 from diphtheria, 34 from diarrhœa, and 34 from small-pox. The highest death-rates from these diseases occurred last week in Salford, Portsmouth, Nottingham, and Hull; whooping-cough showed generally increased fatality, which was largest in Salford and Birmingham. The largest proportional fatality from scarlet fever occurred in Hull, Nottingham, and Sunderland; of measles in Leeds and Liverpool; and of "fever" in Oldham. Scarlet fever caused 24 more deaths in Hull, making 642 that have been recorded since the beginning of July. The 42 deaths from diphtheria in the twenty towns included 18 in London and 13 in Portsmouth; no fewer than 98 deaths from this disease occurred in Portsmouth during the last three months of 1881. Small-pox caused 37 more deaths in London and its suburban districts, and 2 in Salford. The number of small-pox cases in the metropolitan asylum hospitals, which had been 471 and 474 on the two preceding Saturdays, had further increased to 485 at the end of last week; these included 115 in the Convalescent Hospital at Darenth. The new cases of small-pox admitted to these hospitals during last week were 76, against 93 and 78 in the two previous weeks. The deaths referred to diseases of the respiratory organs in London, which had been 434 and 411 in the two previous weeks, rose to 596 last week, and exceeded the corrected weekly average by 52. The causes of 107, or 2·7 per cent., of the deaths in the twenty towns last week were not certified either by a registered medical practitioner or by a coroner. The proportion of uncertified deaths did not exceed 1·5 per cent. in London, whereas it averaged 4·0 per cent. in the nineteen provincial towns. All the causes of death were duly certified in Portsmouth, Plymouth, and Leicester; while the proportion of uncertified deaths was largest in Bristol, Salford, Oldham, and Leeds.

HEALTH OF DUBLIN.

The rate of mortality in Dublin, which had slowly increased from 24·5 to 34·8 per 1000, further rose in the last week of the year to 39·0, a higher rate than has prevailed in any week since the middle of February last. The 261 deaths in the city showed a further increase of 28 upon recent weekly numbers; 39 were referred to measles, 5 to "fever," 2 to whooping-cough, 1 to scarlet fever, 1 to diarrhœa, and not one either to small-pox or diphtheria. The annual death-rate from these principal zymotic disease was equal to 7·2 per 1000 in the city. The fatal cases of measles in Dublin rose to 39 last week, and were equal to an annual rate considerably exceeding that which prevailed from the same disease in any of the twenty English towns. The 5 deaths from "fever" exceeded the numbers in recent weeks.

THE HEALTH OF DUTCH TOWNS IN 1880.

It appears from an official return that the estimated population of the twelve largest Dutch towns in 1880 was 920,552, or little short of a million persons. The birth-rate averaged 39·8 per 1000 of this population, and the death-rate was equal to 28·3, which exceeded by 5·6, or nearly 25 per cent., the average rate in the twenty large English towns. The death-rates in the twelve Dutch towns during 1880 ranged upwards to 31·0 in Maastrecht and 32·5 in Dordrecht. The excess of mortality in these Dutch towns was in great measure due to the great fatality of infants. The deaths of infants under one year of age were equal to no less than 223 per 1000 of the births registered; and infant mortality measured in this manner was equal to 240 per 1000 in Dordrecht, 247 in Utrecht, and 262 in Haarlem. The death-rate from the principal zymotic diseases was not excessive; only one fatal case of small-pox was recorded during the year, and the death-rate from "fever" was lower than the average rate among the twenty English towns. The fatality of scarlet fever, measles, whooping-cough, diphtheria, and diarrhœa did not on the whole compare unfavourable with that recorded in the English towns. The largest proportion of zymotic deaths occurred in Amsterdam during 1880, in which city measles showed epidemic fatality.

HEALTH MATTERS GENERALLY AT HOME AND ABROAD.

CERTIFICATION OF DEATHS FROM "FEVER."

The medical officer of health for Bristol does good service in calling attention to the unsatisfactory way in which deaths from "fever" are certified in that city. The indefinite manner in which the word "fever" is used in certifying causes of death detracts much from the value, from a sanitary point of view, of the statistics based upon the death register which is issued from time to time by the Registrar-General and by medical officers of health. Mr. Davies, the medical officer of health for Bristol, appears to furnish returns to his sanitary authority, the town council, for weeks ending on Wednesday instead of for weeks ending on Saturday. The return for the week ending 14th ult. included three deaths referred to "fever." One was of a man in the Bristol workhouse who died from typhus; and with regard to the other two it is stated that they were referred to "remittent fever," Mr. Davies remarking, "this is the first time within my knowledge that this term has been applied to the cause of death within this city." No clue is given as to the age of the deceased persons said to have died from "remittent fever"; but, objectionable as is this misdescription, it is by no means rare to find in the death register the deaths of children referred to "remittent fever." We agree with Mr. Davies that it is impossible to say with any certainty what is meant by the term "remittent," which is even more unintelligible than such terms as low fever, brain fever, or continued fever, all of which are constantly found in the death register. It is not unreasonable to look to the influence of medical officers of health to obtain a more precise and scientific definition of the cause of "fever" deaths; and this result would assuredly ensue if the relations between medical officers of health and medical practitioners were what it is most desirable they should be. There should be, granted these relations, no difficulty in Mr. Davies, ascertaining what the certifying practitioners in Bristol mean by "remittent fever."

METROPOLITAN ASYLUMS BOARD.

This Board has issued its account of the estimated expenditure up to Lady-day next, and a call is made upon the metropolis for £240,000 to meet this expenditure. Of the whole amount £40,000 is required to make the deficit from the last estimate; £16,000 interest on loans; £2900 cost of the central administration, and £2000 law costs. Deducting the above-mentioned £40,000, £199,000 for the half-year's expenditure remains. Of this nearly £128,000 will be charged to the "Common Poor Fund" account, and raised from the whole of London according to valuation—the richer parishes thus paying in excess of the poorer ones, while the balance, for "maintenance," is paid by the parishes which have sent the patients.

SMALL-POX IN THE UNITED STATES.

The State of California is reported to have quarantined against Chicago in order to prevent the introduction of small-pox. Trains on the Central Pacific Railroad had introduced small-pox into five different counties in California. The Chicago health officers say that if California quarantines against Chicago, Chicago will have to quarantine against New York.

The *Bombay Gazette* reports twelve fatal cases of cholera to have occurred in the week ending December 16th amongst the civil population. The troops have, up to date, remained free from the disease.

A telegram from the Governor of Senegal announces that yellow fever has completely disappeared from that colony. At Goree, however, the disease is still prevailing.

The outbreak of enteric fever in Oldham has almost subsided.

THE SERVICES.

The last mail from the West Indies reports the yellow fever epidemic to have subsided at Barbadoes. The garrison there consists now only of West Indian troops; but it is contemplated to despatch a European regiment shortly in place of the 1st Battalion Royal Lancaster, which was withdrawn in October last.

The Bearer Company of the Army Hospital Corps, under the command of Surgeon-Major W. Johnston, Army Medical Department, left Durban for England in the *Duart Castle* on the 30th ultimo. The Bearer Company proceeded to Natal with the reinforcements ordered to Africa after the Majuba Hill action, and had been encamped near Newcastle for some months in anticipation of renewal of hostilities.

Deputy Surgeon-General J. Holloway, C.B., has been appointed Principal Medical Officer of the Eastern District at Colchester on return from duty in Natal.

Deputy Surgeon-General E. J. Franklyn, M.D., has been ordered to Belfast for duty on return from India.

Surgeon-Major Decimus de Hodgson, A.M.D., has been granted six months' leave to England from India on the recommendation of a medical board.

Probably owing to the fouling of the watercourses, enteric fever has appeared and assumed a serious aspect amongst our troops in Natal.

INDIA OFFICE.—The Queen has approved the retirement from the service of the undermentioned officers: Brigade Surgeon Clarence Cooper, M.D., Madras Army; Surgeon-Major Edmund Poulter Burrows, Bombay Army.

MILITIA MEDICAL DEPARTMENT.—The undermentioned Surgeons-Major resign their commissions, also are permitted to retain their rank and to wear the prescribed uniform on their retirement: George Borlase Childs, 4th Battalion the Royal Fusiliers (City of London Regiment); George Morrison, 3rd Battalion the Gordon Highlanders.

RIFLE VOLUNTEERS.—20th Lancashire Corps: Surgeon John Armstrong is granted the honorary rank of Surgeon-Major. 1st Lincolnshire Corps: Surgeon John West Walker is granted the honorary rank of Surgeon-Major.

ADMIRALTY.—In accordance with the provisions of Her Majesty's Order in Council of April 1st, 1881, Staff-Surgeon Peter Burgess, M.A., M.B., has been allowed to withdraw from her Majesty's Naval Service with a gratuity. Fleet Surgeon Robert Humphrys, R.N., and Fleet Surgeon Patrick Keelan have been placed on the Retired List.

The following appointments have been made: Fleet Surgeon William G. Ridings to Haslar Hospital, vice Breaky; Fleet Surgeon John C. Eastcott to the *Excellent*, vice M'Kenna; Staff Surgeon George Bolster to the *Revenge*, vice Eastcott; Staff Surgeon Edward Meade to the *Penelope*, vice Bolster; Surgeon Alexander M. French to the *Thalia*, for the *Boadicea*; Surgeon Alexander L. Christie to the *Excellent*, vice John N. Browning; Staff Surgeon Ingham Hanbury to the *Revenge*, additional, for service with Marine Battalion in Ireland; Staff Surgeon W. L. Powell to the *Thalia*, for the *Boadicea*.

OUR ARMY.

THE General Annual Return of the British Army for 1880, prepared by the Adjutant-General, affords some interesting information as to the physical condition of the Force. The average strength during the year at home and abroad was 188,986, including 7817 officers. Of the latter 4044 were employed at home and 3773 abroad; of 181,169 non-commissioned officers and men, 87,843 were on home and 93,326 on foreign service. The deaths of officers are not given in the return, but those of the men amounted to 3186, and the number discharged as invalids to 3964, the former being in the proportion of 17·62 and the latter of 21·93 per 1000 of the strength. The mortality has been considerably above, and the invaliding slightly under, the average of the preceding ten years; the return does not enable us to trace where the excess of deaths occurred, but it was probably chiefly due to the disaster at Maiwand. During the year 44,298 men were enlisted, of whom 11,721 were rejected and 7029 failed to join from other causes, leaving 25,535 as the number passed into the service, or a little less than one-seventh of the average strength. If the number included under the head of "rejected" prior to and after attestation were all rejected on medical inspection, it would give the proportion of 265 per 1000 deemed physically unfit for service, which is considerably below the average of previous periods. Of the recruits passed into the service 776 per 1000 were raised in England, 74 in Scotland, and 150 in Ireland. The nationality of the men serving in the army on January 1st, 1881, was as follows per 1000 of strength:—English 697, Scotch 81, Irish 209, born in India and the Colonies 12, 1 foreigner. Compared with the composition of the force in 1870, when the short service system was introduced by Lord Cardwell, these results show an increase to the amount of 83 per 1000 in English, a slight decrease in Scotch, and a reduction of 75 per 1000 in Irish. Detailed tables are given in the return of the ages, height, and chest measurements of the men serving on January 1st, 1881, with summaries of the same information for the preceding ten years, from which the following interesting results are obtained. As regards age, the proportion per 1000 serving in 1881 and 1871 respectively was—

	Under 18.	18 and 19.	20 to 24.	25 to 29.	30 and upwds.
1871	29	161	273	217	320
1881	17	87	413	254	229

So that under the present system there has been a marked reduction in the number of boys and growing lads, a great increase in men from twenty to twenty-five, and a moderate increase from twenty-five to thirty, with a reduction of those above thirty equal to nearly one-tenth of the force.

The relative height of the men serving on Jan. 1st, 1881 and 1873, the earliest year for which the results are available, was—

Per 1000 of strength.	Under 5ft. 6in.	5ft. 6in. to 5ft. 7in.	5ft. 7in. to 5ft. 8in.	5ft. 8in. to 5ft. 9in.	5ft. 9in. to 5ft. 10in.	5ft. 10in. and upwds.
Jan. 1st, 1873 ..	212 ..	209 ..	206 ..	162 ..	106 ..	114
Jan. 1st, 1881 ..	190 ..	212 ..	209 ..	166 ..	108 ..	115

This shows a reduction in the proportion of men under 5 ft. 6 in., a considerable increase in those from 5 ft. 6 in. to 5 ft. 7 in., and a slight increase at the other heights, the general result being that the height of the men now serving is somewhat above that of the Army in 1873.

The chest measurements also of the men serving on Jan. 1st, 1881, furnish satisfactory evidence of an improve-

ment in the physique of the troops. We cannot find any detailed information as to these measurements of an earlier date than Jan. 1st, 1875, but the following results are obtained for the two years:—

Proportion per 1000 serving on	Under 33in.	33in. to 34in.	34in. to 35in.	35in. to 36in.	36in. to 37in.	37in. to 38in.	38in. & upwds.
Jan. 1st, 1875	24 ..	57 ..	127 ..	187 ..	213 ..	179 ..	213
Jan. 1st, 1881	18 ..	32 ..	112 ..	183 ..	220 ..	133 ..	103

This table shows a very marked decrease in the proportion of chests of smaller size; and although there is also a decrease in those of 38 inches and upwards, this is an obvious consequence of the reduction in the number of men serving above thirty years of age. The result of the three tables is satisfactory, as showing that under the present system a considerable proportion of the immature and insufficiently developed men has been eliminated from the ranks. We recently pointed out that the recruiting returns exhibited a similar improvement in the physical qualities of the recruits now being passed into the army (THE LANCET, April 2nd, 1881).

The state of education in the army is very satisfactory compared with what it was so recently as ten years ago, as will be seen by the following summary of the educational acquirements of the non-commissioned officers and men serving on the 1st January, 1870, and 1881 respectively:—

Per 1000 of strength.	Neither read nor write.	Read but not write.	Only read and write.	Better educated.
Jan. 1st, 1870	78	79	783	60
Jan. 1st, 1881	40	34	249	677

Of the "better educated" now serving, 271 hold fourth class certificates, 149 third class, 143 second class, 6 first class, and 108 do not hold certificates. There is no similar information regarding the acquirements of this group in the earlier periods.

Notwithstanding the marked advance in education, we regret that the records of courts-martial and of the fines inflicted for drunkenness furnish anything but pleasant evidence of the habits of our soldiers. During the year there were 2264 trials for being "drunk on duty under arms" as against 1428 in 1870, and 1884 for drunkenness against 2175, or, taking the two offences together, there were 4148 courts-martial against 3603, being an increase of upwards of a seventh. This may possibly have been to some extent a result of changes introduced into the service by the Army Discipline and Regulation Act of 1879. But, in addition to these trials by court-martial, it appears that 22,029 men were fined for drunkenness, being in the proportion of 122 per 1000 of the strength, or nearly one-eighth of the men serving; the number of fines thus inflicted was 40,684; three men were fined twelve, and the same number ten times. The only satisfactory feature in the matter is that the number of men fined and of fines inflicted have both been lower than in any of the preceding ten years.

REPORT ON THE HEALTH OF THE NAVY.

THE statistical report on the health of the navy for 1880, prepared by Deputy Inspector-General Dick, has just been issued. It shows the average strength to have been 44,770, the cases of sickness 52,487, the deaths 563, the invaliding 1393, and the mean daily sick 20,124. These numbers give as the proportion per 1000 of mean strength: 1172 cases, 12·57 deaths, 31·11 invalided, and 44·94 constantly sick. Compared with the preceding year there has been a considerable increase in the cases and deaths, but a reduction in the invaliding, while the ratio of mean sick in the two years closely corresponds. Compared, however, with the average of the last ten years, the death-rate alone shows an excess. This was chiefly due to the loss of the *Atalanta*, in which 279 hands perished; if these are deducted the death-rate would be only 6·34 per 1000, or 3·92 per 1000 under the average. The prevalence of disease varied from 919 cases per 1000 of strength on the home station to 1591 on the North American and West Indian—the mortality from 3·70 on the latter to 57·19 in the irregular force; or, omitting this as resulting from the loss of the *Atalanta*, to 12·08 on the West Coast of Africa and Cape of Good Hope station; the invaliding from 25·17 in the irregular force to 50·33 on the West African and Cape; and the mean daily sick from 40·33 on the Home to 55·42 on the China station. The great excess of admissions on the North American and West Indian station was from diseases of the cellular and cutaneous systems, probably ulcers—though on that point no information is given,—diseases of the digestive system, especially diarrhœa and dyspepsia, and from syphilis. On the East Indian station the amount of sickness was very nearly as great, the principal diseases being those of the cellular tissue and cutaneous system, paroxysmal and continued fevers, and diseases of the digestive system. A large proportion, amounting to about two-sevenths of the cases of paroxysmal fevers, occurred in the *London*, permanently stationed at Zanzibar, and chiefly in the first five months of the year. The specific cause of the large proportion of cases is doubtful, but it is noted that the men whose duties confined them to the ship suffered to a much greater extent than those employed in the cruising boats, who did not furnish a single case whilst away on detached duty, and during their alternate month on board the *London* were not attacked in half as large a proportion as the others. The prophylactic use of quinine in four-grain doses, night and morning, during the period of the great prevalence of paroxysmal fever in March and April, is stated to have been attended with marked benefit in checking the disease. On the China station diseases of the cellular tissue and cutaneous system, and of the digestive system, and syphilis and gonorrhœa furnished five-sixths of all the cases; their prevalence, however, with the exception of the first of these classes, was under the average of the preceding ten years. The rate of mortality did not exceed 12 per 1000 on any of the foreign stations, and there was no occurrence of fatal disease which seems to require notice.

The results showing the influence of age on mortality in the navy have been completely upset by the loss of the *Atalanta*, which, being a training ship, had a very large proportion of lads on board. If the deaths by injuries, under which this calamitous event is entered, be deducted, the ratio of mortality by disease per 1000 of average strength will be as follows:—Between fifteen and twenty-five years 3·8; between twenty-five and thirty-five years 3·67; between thirty-five and forty-five years 8·63; and above forty-five years 13·39. These figures indicate a very low death-rate under thirty-five; above forty-five the number serving is too small—only 1120—to warrant any very reliable deductions. The volume shows very satisfactory results as regards the health of the navy during the year under review. We would suggest to the author of the report, however, that he should enter a little more into detail on the subject of the most prevalent diseases, as the absurd and injudicious curtailment of the tables in the appendix, enforced upon him by the governmental committee on statistics, has affected the report most injuriously, from a scientific and professional point of view, and has deprived us of the means of comparing the influence of special diseases on the health of the men, or of tracing those which may be considered likely to have resulted from insanitary conditions of the ship, food, clothing, or duty. The appendix to the volume contains the usual tables of the prevalence of syphilis and gonorrhœa at the various seaports, distinguishing between those under and those not under the Contagious Diseases Acts, but without any comment upon the subject in the report itself. We presume Dr. Dick considers that it has been already sufficiently discussed, and that a repetition of the facts developed by these tables is unnecessary, and would be tiresome.

WILLS AND BEQUESTS.

THE will and codicil of Mr. Thomas Willis, of Hove, Sussex, physician, who died on August 4th last, have been proved by Mrs. Laura Willis, the widow, Mr. Edward Cooper Willis, the son, and Mr. John Wilson, the executors, the personal estate being over £10,000. The testator leaves legacies to his wife, sons, daughters, grandchildren, and others, and the residue of his property upon various trusts for the benefit of his wife and four children.

The will of George Alexander Simpson, M.D., of Highgate-lane, Highgate, who died on October 13th last at Banchory, Aberdeen, has been proved by Mrs. Jane Howzell Simpson, the widow and sole executrix, the personal estate

amounting to nearly £4000. The testator appoints his share and interest under the will of his late father, Dr. Alexander Simpson, of her Majesty's Indian Service, to his son, Alexander Malcolm Simpson, and subject thereto gives the whole of his estate to his wife.

The will of Samuel Prall, M.D., of Town Malling, Kent, who died on August 23rd last, at Broadstairs, was proved on the 2nd ult. by Mr. Henry Edward Prall, the brother, and Mr. M. A. Adams, the executors; the personal estate amounting to £2300. The testator bequeaths to his wife, Mrs. Emma Prall, his household furniture and effects; the goodwill, &c., of his practice as a surgeon is directed to be sold, and the proceeds with the remainder of his property held upon trust for his wife for life, or until she shall marry again, and then for his children.

The will and codicil of Dr. Archibald Billing, of 34, Park-lane, who died on September 2nd last, have been proved by Mr. Alexander Sim, Mr. George Long, and Mr. Edmund Henry Ellis, the executors, the value of the personal estate exceeding £45,500. The testator bequeaths to his wife, Mrs. Caroline Billing, all the cash in house and at bankers, and his furniture, plate, pictures, household effects, horses and carriages; and to his executor, Mr. Ellis, £100. The residue of his real and personal estate is to be held upon trust for his wife for life; at her decease a sum of consols is to be set aside to pay £100 per annum unto his daughter Florence until her marriage, upon the happening of which event the said consols are given to three granddaughters; and the ultimate residue is to be divided between his four daughters, Mrs. Agnes Sim, Mrs. Rosa Hamilton Long, Miss Florence Billing, and Mrs. Edith Niebold Newton.

The following legacies have recently been left to hospitals and other medical charities:—Mrs. Sarah Smith, of 2, Winifred-dale, Bath, £100 to the Royal United Hospital, Bath.—Rev. Frederick Dobson, of Stratfield-Mortimer, Berks, £1000 to the Royal Berkshire Hospital.—Mrs. Caroline Coller, of 37, Montpelier-square, Brompton, £100 to St. James's Dispensary.—Mrs. Sarah Crozier, of 20, Clifton-road, Brighton, £300 each to the Sussex County Hospital and the Children's Hospital, Dyke-road, Brighton.—Miss Susan Brown, of Weston-super-Mare, £300 each to the Hospital at Taunton, the Weston-super-Mare Hospital, and the Weston-super-Mare Sanitorium.—Sir John Musgrove, Bart., of Rusthall House, Speldhurst, Kent, £500 to the Tunbridge Wells Infirmary.—Mr. William Ward, of Honduras Wharf, and The Lawn, Brixton, £100 each to the Royal Hospital for Incurables, Putney Heath, and the Royal Hospital for Diseases of the Chest, City-road.

Correspondence.

"Audi alteram partem."

PERMANGANATE OF POTASH AND SNAKE POISON.

To the Editor of THE LANCET.

SIR,—With reference to the correspondence which has appeared in the London daily press, regarding the researches of M. Lacerda, of Brazil, on the treatment of snake poisoning, to which you refer, I may remark that I have not had the advantage of perusing that correspondence, my attention to the subject having been attracted by an extract in the Calcutta *Englishman;* but it would appear that M. Lacerda's deductions are based upon some experiments made with viper poison. In the last paragraph of your leading article on M. Lacerda's experiments, contained in your issue of Nov. 5th, you make the very apposite observation that it is probable that antidotes, if they exist, are not equally efficacious for all serpent poisons. You have here struck a most important keynote. I observe that Mr. A. Wynter Blyth, in the same issue of your journal, declines to accept M. Lacerda's claims "to have discovered that permanganate of potash is an antidote to cobra poison." Not having had an opportunity of examining the account of M. Lacerda's experiments, I am not in a position to judge how far he is justified in advancing any such claims; but inasmuch as the physiological effects of cobra poison differ so materially from those of viper poison, with which M. Lacerda seems to have experimented, any deductions in regard to the value of an antidote based upon experiments with one particular poison cannot be conclusively or even fairly applied to both. It is quite possible, as you have suggested, that an agent which would prove to be an antidote in the one case would be utterly powerless in the other. The poison of the cobra is one which affects particular nerve centres, while that of the viper is essentially a blood poison. But be this as it may, there can be no question that if it is proved—as is admitted by Mr. Blyth—that permanganate of potash possesses the power of neutralising snake poison while lying in the tissues, a very important practical advance has been made. Hitherto the only means of saving life in an efficient snake-bite has been immediate ligature and subsequent amputation. Now, if we have an agent which is capable of neutralising the poison lying in the tissues below the ligatured part, we may save the life of the victim without sacrificing his limb. After considerable experience in the subject of snake poisoning, I am persuaded that no decided opinion should be given until after the completion of most searching and oft-repeated experiments. I have performed thirty experiments with cobra poison and permanganate of potash, and will here set forth what results appear to be fairly deducible therefrom. I may state that I am still continuing the experiments, which I will hereafter publish *in extenso*.

1. That in dogs no appreciable symptoms of cobra poisoning followed the hypodermic or intravenous injection of a water solution containing from two to seven centigrammes of cobra poison when previously mixed with from one to three decigrammes of permanganate of potash, though under ordinary circumstances such quantities are more than sufficient to produce fatal results.

2. That when similar quantities of a water solution of cobra poison were hypodermically injected into dogs, and were followed either immediately, or after an interval of three minutes (the longest interval I have yet tested) by the hypodermic injection into the same part of a solution of from one to six decigrammes of permanganate of potash, no appreciable symptoms of cobra poisoning resulted.

3. That when glycerine was used instead of water to dissolve the dried cobra poison, the permanganate of potash appeared to have no power over the virulence of the cobra poison.

4. That after the development of symptoms of cobra poisoning the injection of the permanganate of potash, whether hypodermic, or intravenous, or both, failed to exercise any influence upon the symptoms.

5. That permanganate of potash possesses no prophylactic properties in cobra poisoning, since death followed the hypodermic injection of three and a half centigrammes of cobra poison in water solution, in the case of a dog which had been hypodermically injected a few hours previously with eight decigrammes of permanganate of potash in solution.

6. That it would appear to be absolutely necessary that the permanganate of potash, to prove efficacious, should come into actual contact with the cobra poison.

What would be the behaviour of the permanganate in viperine snake poisoning I have yet to learn, and I have still to perform many experiments before I can speak positively as to its practical value in cobra poisoning. Even if it is found that permanganate of potash hypodermically injected is an antidote, I fear that, however scientifically valuable such a discovery may be, it will be of no great practical value in India for many years to come, seeing that not one per cent. of the victims of snake poisoning would be likely to come under the treatment of persons capable of efficiently applying the remedy. Still, it will be something if it can be shown that life can be saved in what has hitherto been believed to be a hopeless case. In conclusion, I would offer as a suggestion that it might be advisable to try the permanganate of potash in cases of the bite of rabid animals. I would recommend that, after incising the wounds, the parts should be well hypodermically injected with the agent—say with a solution of two grains to one drachm of water—the wounds being afterwards dressed with powdered permanganate. If the agent possesses the power of neutralising the subtle virus of the snake, it may possibly possess a like power over the virus which causes hydrophobia.

I am, Sir, yours truly,

VINCENT RICHARDS,
Late Member of the Indian Snake-poisoning Commission.

Goalundo, Nov. 26th, 1881.

"ON THE POSITION OF SHIP SURGEONS."

To the Editor of THE LANCET.

SIR,—I trust your readers will not judge the position of all ship surgeons by the experience of your correspondents on board the American liners. During the three years I served in the P. and O. service, I experienced the greatest courtesy from the seven commanders and about eighty different officers with whom I sailed. On no occasion had I the slightest difficulty in "laying up" anyone on board, from the chief officer to the little light bearer attending upon the smokers. If a sick Lascar from the deck or African from the engine-room required special diet, whatever the steward's store contained was at my disposal. A daily list was sent to the captain of hands unable to perform their duties; and at the end of the voyage a register of sick, with extra diet required, was forwarded to the directors; and I never heard that I was too extravagant with medical comforts. The surgeon always dines in the saloon; is expected to make himself sociable with the passengers; to assist in getting up amusements for them; and when he and the captain are whist players, they generally cut in together. He has a good cabin, separate from his surgery; and when in harbour really takes more leave of absence than any other officer on board can possibly find time for. When passenger on board one of the Allan steamers I noticed that the surgeon messed with the second and third officers except when he had a special invitation from the captain to dine in the saloon; and was generally addressed by his juniors as "Pills." As to pay in the P. and O. Co., we had £13 a month West of Suez and £16 on the East side, which was brought up to about £300 a year by extra pay from Government on account of naval and military invalids, and presents from sick passengers. Since leaving, however, I believe the pay has been reduced to £10 a month all through. The only snub he is likely to get in the service is from the port authorities in London, who will not receive from him the usual bill of health, requiring the report to be signed by the commander.

I am, Sir, yours faithfully,

THOS. SCORESBY-JACKSON, M.D.

Walthamstow, Jan. 2nd, 1882.

To the Editor of THE LANCET.

SIR,—While fully concurring with some of the statements put forward on the above subject by Dr. Irwin, I feel constrained to take exception to others. I agree with him as to the market being overstocked with men, and, I am sorry to say, by a great many unworthy members of a grand profession; but the deduction he draws from this fact, that a professional man thereby loses his reputation and status, I deny; and I think you will agree with me that a man makes or mars his own reputation, and will not lose it without a sufficient cause. The statement that they are selected without reference as to character, &c, given bad quarters, or interfered with in the performance of their duties, in justice to the Company to which I belong I must deny emphatically.

As we read further, we are compelled to smile at Dr. Irwin's account of the snubbing, &c., which he received; although pathetically portrayed, still the story contains more of bathos than pathos. We all know that a captain is supreme on any vessel he commands, be it an ironclad or a smack, but it entirely depends on the surgeon whether he reigns supreme in his own department or sinks to a lower position. In all my experience I cannot call to mind a similar instance to that which he so graphically describes; but perhaps I may ascribe the fact to my intolerance of snubs or indignities of any kind, and perhaps a *soupçon* of firmness in maintaining my position in all its integrity. As to medicines, you are allowed, in the Inman Company at least, to order any extra at your own discretion. As to attendance, I may say that I have always found, on embarking, my room (a splendid one) put in perfect order by my steward, and should I have occasion to wait for a removal of slops, &c., I should most certainly feel inclined to command, rather than beg, for their removal. By these few remarks I do not mean to reflect in any way upon Dr. Irwin's individual statements, nor do I assert that the position of a ship surgeon is not capable of great improvement; but what I say is, that in some companies at least a gentleman and surgeon may not only possess a good reputation and high professional status, but also have good quarters and a fair salary to begin on anyway; but this is not everything, of course. Well, then, let us look at the real grievances carefully, and then something may be done, but sweeping condemnation of everything and everybody will never remedy anything. In some lines it is incumbent on the surgeon that he remain on board the vessel, thereby perhaps he has only four days out of nine on shore, when he really might as well be on shore employing his time valuably. If any accident did occur on board he could only send it to hospital, which the officer on watch could do as well, and it is very hard on men, especially married men, to be lying in the river when they might be at home by a cosy fire. The salary is fair to commence: £120 a year, and board, &c., for a beginner is always more or less sick and unaccustomed to the multifarious duties to be done on a large ocean steamer, where he has in the spring eighteen hundred or two thousand souls on board. In the service they do not make a surgeon-major at once out of a probationer, so I think a man ought to be satisfied with it at first; but I certainly think that it would be a great advantage to the company as well as to the surgeon to increase their salary annually, thereby providing competent and experienced men in the mercantile marine, who will be proud of their position, in no way inferior to any of the services.

I am, Sir, yours faithfully,

ROBERT T. A. O'CALLAGHAN,
Surgeon R.M.S. *City of Berlin*.

Inman S.S. Company, Water-street, Liverpool.

To the Editor of THE LANCET.

SIR,—The conflicting testimony and the various opinions expressed in your journal upon the subject of ship surgeons unmistakably prove that the varying aspects of this question are very complicated.

The necessity of providing medical attendance for persons sojourning on board ships is enforced by public opinion and confirmed by law. The discretion in choosing the medical attendant must, it seems to me, be left with the employers of that kind of labour, and is practically regulated by the principle of supply and demand. The medical officer on board ship is a servant of the company under which he sails, and takes the position on board ship which is assigned to him by the owner. The port surgeon is responsible to a certain extent for the proper medical equipment of the vessel. If such be the case, the question of salary, cabin, &c., must remain under the control of his employer, and the minor appointments and etiquette will be governed by the wisdom or ignorance of his superior executive officer.

The real question of sanitation afloat is, I believe, a very important one, as the want of it very frequently means a serious crippling of the efficient management of a vessel, and thereby danger to the public. I will mention one instance from personal experience. On board one of the finest liners from the port of Liverpool the stench arising from a number of live rabbits and pigeons penned up was, when the wind was slight, intolerable; and this odour, together with the smells from a small flock of sheep, also cooped up, slightly diluted with air swept through the cabins of the second and third officers, prevented, to my knowledge, a certain portion of their necessary sleep, and put them more or less upon the sick list. No expostulations of mine were of any avail, although the captain admitted that the smell was disgusting. I contend that such a state of things must weaken the efficiency of the work of those officers, and thus endanger the safety of an unthinking public.

If on some such grounds as these the pressure of public opinion will exert its influence and public carriers will learn that their interest, the interest of their servants, and that of the public are identical, then, and then only, will medical men on board ships take the position which their office and their education demand.

I remain, Sir, yours faithfully,

January, 1882. JUSTITIA.

POISONING BY ACONITE.

To the Editor of THE LANCET.

SIR,—I venture to send you the following account of a case of aconite poisoning that occurred in my practice some few years ago, and of which I happen to have preserved notes.

On July 18th, 1876, about 10.45 P.M., Miss M. A. H——, aged twenty-four, having pain in her back, went to the cupboard for some "lumbago drops" she kept there, but by mistake got hold of a bottle of linimentum aconiti (B.P.), and having dropped out thirty drops of the liniment took it, and, not discovering her mistake, went back to bed. In about ten minutes she felt a tingling in the hands and fingers, which also "felt as if drawn up," then felt the same sensations in her lips, tongue, and cheeks, which also "felt as if drawn up," these sensations being, in addition, accompanied by a feeling of "numbness." A short time after the tingling and numbness were experienced in the feet and legs. About an hour from the time she took the aconite she "felt queer all over," also "as if the bedclothes were a dreadful weight," and "felt chilled all over," but "breathed all right." She also "felt as if she were losing her senses at times," and at other times "was quite clear." She did not perspire at all, and there was no desire to urinate or defecate. Gradually she felt so uncomfortable that she got up, but "as soon as she got up she felt inclined to lie down upon the floor;" however, she managed to get downstairs. Feeling "so starved, she wanted to get by the kitchen fire." Arrived at the bottom, she fell down insensible. The noise she made aroused her sister, Mrs. B——, who came down and found Miss H—— lying on her side, perfectly unconscious. She was icy cold, and there was no circulation as far as Mrs. B—— could tell. Her head was thrown back, and the muscles of the neck were strongly contracted, so much so that Mrs. B—— "had great difficulty in pulling her head forwards." Her hands and arms were fixed in front of her chest, her face deadly pale, lips blue, and she was dark under the eyes, the lids of which were half open, the eyeballs twitched. Mrs. B—— thinks Miss H—— was like this about ten minutes, and then gradually, but rapidly, recovered consciousness and was quite rational. Mrs. B—— got her into the kitchen and laid her down upon the floor. Miss H—— now commenced being unconscious again, and was much as in the previous attack. As soon as she recovered, which she did in a few minutes, an emetic of salt and water was administered, and this soon brought on vomiting freely. About 1 A.M. I saw her. She was deadly pale, not cold; pulse very quick and irregular, and very intermittent; respiration apparently unaffected; quite conscious. Pupils rather large, but hardly what could be called dilated; in fact, I noticed afterwards that she had rather large pupils when well. She did not sweat in the least. She complained of extreme weakness, and of tingling and numbness in hands, feet, legs, tongue, face, and lips, but nowhere else. I did not take the temperature, but to the touch it did not differ much from normal. She seemed almost moribund, and for some time I expected her death every minute. Sometimes the pulse would become imperceptible, and she half closed her eyes and appeared as if dying. I administered an emetic of twelve grains of sulphate of zinc at once, and then puked with warm water and animal charcoal. This caused free vomiting, after which I continued administering animal charcoal and water, with brandy. In a few minutes I repeated the emetic and soon had the stomach freely emptied, and in about an hour I perceived distinct improvement. She now went to sleep on the floor, and about 3.30 A.M. she was so much better that I left her. Her pulse was still very irregular and intermittent. In the morning she was quite well, with the exception of a little numbness and tingling, and some rather severe bruises she got in her fall. The dose in this case was only about half a drachm of the pharmacopœial linimentum aconiti. She dropped it into a teaspoon, and in the morning showed me about the quantity, and I carefully measured it. This was equal to about 600 drops of the ordinary tincture of aconite, and may be regarded in respect of this particular woman as the utmost dose from which recovery would have been possible. The poison was taken at about 10.40 P.M., and she was not seen by anyone until her sister, Mrs. B——, found her unconscious about 11.45. She did not have the emetic until about 12.20, and I did not see her until about 1 A.M., or two hours and a half from the administration, at which time she was apparently moribund.

There was not the least smell of the liniment in any of the vomit; and I fancy it must pretty nearly all have undergone absorption, and produced the maximum lethal effect which it was capable of doing upon her. There was no paralysis, but intense prostration of the vital powers, no doubt, I think, due to the extraordinary weakness, irregularity, and intermittence of the heart.

I was much surprised by the complete absence of perspiration, having always regarded this as the first and most constant result of the administration of aconite medicinally. The tingling and numbness, the deathly pallor, and extremely irregular, weak, and intermittent action of the heart, form together, I think, an extremely characteristic assemblage of symptoms.

I am, Sir, yours obediently,

December 29th, 1881. WM. HARDMAN.

"BRIGHTON AND THE REGISTRAR-GENERAL'S MORTALITY STATISTICS."

To the Editor of THE LANCET.

SIR,—All my spare time having been taken up by the Health Congress recently held in Brighton, I did not see your article of Dec. 17th until it was too late to have my letter inserted in the number for Dec. 24th. I now wish to make a few observations, to which I trust you will kindly give a prominent position in your journal.

In my letter to the *Standard*, I never for a moment intended to imply that I considered an injustice had been inflicted on Brighton by the Registrar-General; on the contrary, I feel greatly obliged for the courteous and considerate attention given to my communications by the head of the Statistical Department.

Some little time since, I wrote to Dr. Ogle and pointed out that the introductory remarks in the weekly report were vague in stating that the highest proportional mortality from scarlet fever had shown itself in Hull, Nottingham, and Brighton, and that unless the *number* of deaths and the *rate per 1000* were given the public would take an exaggerated view of the mortality, and imagine it to be much greater than it really was. After some correspondence, Dr. Ogle kindly intimated to me that a portion of my suggestions would in future be adopted in the introductory remarks of the weekly report and the rate per 1000 given, but that he did not see his way to giving the number of deaths without also giving the population, and that to do so would be cumbersome, space being limited.

I can assure you that I was as much astonished as yourself at the false inferences drawn by the Doctor of Divinity and the Fellow (and Gold Medallist) of the Royal Society, that a rate of 1·0 per 1000 from "fever" meant 107 deaths reckoned on the gross population of 107,934; and my letter to the *Standard* was written with the intention of showing how the rates in the Registrar-General's Weekly Report were likely to be misunderstood by the public, of whom I now believe not one in a thousand knows how the death-rates are obtained, or that they are made on an annual basis, and are *annual* death-rates. It appears to me that the statements and figures in the introductory remarks of the Registrar-General's Weekly Reports are read in the most careless manner, and conclusions jumped at without any consideration. Of course, if people would only take the trouble to put the figures on paper, as you have done, and find that the general death-rate of 21·0 per 1000 taken on the gross population of 107,934, would give 2292 deaths instead of 44, possibly their eyes would be opened to the false conclusions which they formed from a casual and careless reading.

When I wrote to the *Standard* (which quotes many of your articles), I gave instances of two highly educated men who did not properly understand the figures in the introductory remarks of the Registrar-General, although the latter distinctly states that the rates are *annual* rates. Since then I have made numerous inquiries, and I find that the misconception is very general, not only among the public, but also among medical men. While writing this letter I have had an opportunity of asking an intelligent medical

practitioner what his impression was on the subject, and he informed me that it was identically the same as that of the Doctor of Divinity and the Fellow of the Royal Society.

More than one medical officer of health during the recent Health Congress told me, in answer to my inquiries, that their experience went also to show that the rates are misunderstood by the public. I may venture to say that not even the members of the medical profession as a rule, who are not engaged as medical officers of health in making out death-rates and estimating populations, know anything about how death-rates and populations are estimated, simply because their attention is not given in that direction (the subject until lately has not been taught in the medical schools). I firmly believe that the general death-rate is as carelessly read as is the "fever" death-rate, and the same hazy notions entertained, for whenever the weekly rate is, say, for instance, by way of comparison, twenty-six or twenty-seven in one week, I receive numerous and anxious inquiries and letters on the subject, but when the death-rate is as low as eleven or twelve, no one appears to see it or take the least notice, and I draw the inference therefrom that the weekly reports, which should be read one week with another for several weeks, are misunderstood. I maintain that the public do not understand the weekly reports of the Registrar-General as conveyed by the newspapers. I draw a great distinction between saying that the reports mislead or that they are misunderstood: the first I should not dream of, the second I boldly assert.

Your article concludes with the hope that I have ascertained the cause of the recent outbreak of typhoid fever in Brighton; my answer is, that I think I have. I have reported on the subject to my sanitary authority. I believe I succeeded in tracing the outbreak to the propagation of the disease through the medium of milk, having had a few scattered cases previously, and even those cases, I fancy, we were mainly indebted to London for, as in the case of Lord Cadogan and others. Were it not for the importations of infectious diseases from London, Brighton I think would remain pretty free from that class of diseases.

The number of deaths from zymotic disease s given in the tables of the weekly report; but very few see the reports, and only take their information from the newspapers, in which the introductory remarks of the weekly reports, and not the tables, are given.

If the Registrar-General could be induced to give the weekly population on which the rate is struck, the number of deaths, and the rate per 1000, then, unless the reader is very obtuse indeed, the statements and figures would be understood.—I am, Sir, yours truly,

R. P. B. TAAFFE, M.D. Lond.

Dec. 26th, 1881. Medical Officer of Health for Brighton.

*** Dr. Taaffe is undoubtedly right in asserting that even the more educated portion of the general public are grossly ignorant of the true meaning and construction of annual death-rates. Annual death-rates are, however, so essential to those initiated in vital statistics, for comparative purposes, that so long as the figures only mislead the uninformed, we cannot afford to surrender such a convenient standard for comparison. It appears to us, moreover, that Dr. Taaffe's proposed remedy, the publication of what he calls the "weekly population," by means of which the annual death-rate in a week is calculated, would still more effectually bewilder the uninitiated, rather than assist them to understand the construction and meaning of an annual rate.—ED. L.

SWALLOWING ARTIFICIAL TEETH.

To the Editor of THE LANCET.

SIR,—Your impression of December 10th contains the report of a case in which a plate with two artificial teeth was swallowed, and passed per anum without difficulty. The following case is still more worthy of record:—

On the 6th May, 1871, I was asked to see a tradesman's son, who told me he had swallowed some artificial teeth unconsciously during the previous night. He was, I knew, subject to epileptic fits, and I thought that the occurrence might have taken place during one of these. He complained of pain in the stomach, and had taken a dose of castor oil before I saw him. I advised him to eat suet-pudding, rice, and other "stodgy" forms of nutriment, and to take no more aperient medicine. His bowels acted freely in the evening, but the motion contained nothing unusual. The following day he was free from pain, but on the 8th his bowels again acted, and immediately afterwards he felt sharp pain in the lower part of the back. On examining him per rectum I could just reach the foreign body with the tip of my finger. I administered a large enema of gruel and salad oil, and this was immediately discharged into the night-stool, together with the teeth. My patient, after cleansing the latter, returned them to his mouth, and went out to supper. Now comes the remarkable part of the case. On the 24th May, 1880, I was again asked to see him, and found that during a violent epileptic fit he had once more swallowed the *same* plate and teeth. His wife was with him when the accident happened, and did all she could to prevent it. He was free from pain, and had no tenderness in any part of the abdomen. I recommended the same diet as before; but nothing was seen of the teeth till the 25th of June, more than a month after he had swallowed them, when he passed them with a motion without pain.

The plate was of gold, and had three teeth attached to it; it was in shape very similar to that described by Mr. Palmer, but was about one-third of an inch wider, having a ring at one end and a sharp hook at the other. I regret to say the plate has been destroyed, but I have the model of the mouth from which the plate was made, and which shows its exact size. I am, Sir, your obedient servant,

Norfolk-crescent, Dec. 1881. JOHN EASTON, M.D.

FARMAR AND SEALEY FUND.

To the Editor of THE LANCET.

SIR,—With reference to my letter which you so kindly inserted in THE LANCET of October 15th last, in which I mentioned the fact of a subscription being in progress for a testimonial to Corporal Farmar, V.C., and Private Sealey, of the Army Hospital Corps, for their gallant conduct at the disaster of Majuba Hill, and gave a short account of the wounds by which they had been disabled for further military service, I have now the pleasure to state that £170 have been subscribed, and that this amount, equally divided, has been presented to the two men by Sir William Muir, the Director-General of the Army Medical Department. The sum named includes a generous donation of twenty-five guineas from the family of the late Surgeon Landon, A.M.D., under whose directions Corporal Farmar and Private Sealey were acting at the time that lamented young officer received his fatal wound. The presentation has been notified by a circular from the Director-General to the officers and men of the Army Medical Department.

I am, Sir, your obedient servant,

THOS. LONGMORE,

Surgeon-General, H. P., Professor of Military Surgery.

Netley, Jan. 3rd, 1882.

NERVE-STRETCHING.

To the Editor of THE LANCET.

SIR,—The stretching of the ischiatic nerve in cases of tabes has been frequently performed of late in this country, and has been a subject for discussion in medical Societies; but the latest phase into which this operation has entered recently on the Continent seems to be as yet unknown to the profession in England. I think therefore that the following abstract from a letter, which I received a few weeks ago from Munich, might interest your readers:—

"The newest thing out now is the stretching of the ischiatic nerve without the use of the knife, or, as it is termed, subcutaneous nerve-stretching. The patient is placed on his back, deeply narcotised, and his femur is then, with a sufficient amount of force, flexed against his abdomen. The theory is that by this procedure the ischiatic nerve is stretched round the neck of the femur. The results in the cases treated in this way by Professor Nussbaum in Munich, and by Professor Billroth in Vienna, are said to be satisfactory, and there have been no evil results, as luxation or laceration, as might be expected to occur in connexion with such violent manipulation."

I am, Sir, truly yours,

Finsbury Pavement, Jan. 2nd, 1882. G. LUGWIG, M.D., &c.

EDINBURGH.

(From our own Correspondent.)

MEDICAL matters have been very quiet in Edinburgh lately. The medical classes rose for the Christmas vacation on Friday, December 23rd, and reassembled on Wednesday, January 4th. The break was not a long one, but was very acceptable; both students and teachers are hard worked in Edinburgh at present.

The annual meeting of the contributors to the Royal Infirmary was held on January 3rd, the Lord Provost presiding. The report which was presented by the managers showed that the number of patients remaining in the hospital at 1st October, 1880, was 458; 5288 patients were admitted between 1st October, 1880, and 1st October, 1881, the total being 5746. Of these there were—Dismissed cured, 2801; ditto relieved, 1651; ditto on other grounds, 325; died in the hospital, 475—total, 5252; patients remaining on Oct. 1st, 1881, 494. The daily average number of patients in the hospital during the year was 520; the greatest number at any one period was 576, the lowest 453, and the average time during which each patient remained under treatment was thirty-three days. Of the 5252 cases treated to a termination during the past year, there were:—From Edinburgh, 2721; from Leith, 421; from the country, 2110. The number of deaths which took place in the new infirmary within forty-eight hours after admission was 79. These were mostly cases of severe injury of a hopeless character, and they unduly raise the rate of mortality in the hospital. The percentage of deaths to the whole of the ordinary medical and surgical cases treated is 8·0. Deducting the deaths that occurred within forty-eight hours after admission, the percentage is reduced to 6·5. The number of deaths which took place in the fever house within forty-eight hours after admission was 15. The percentage of deaths to the whole of the cases of infectious disease treated in the old infirmary was 10·0; deducting deaths within forty-eight hours after admission, 7·1. The number of patients treated in the convalescent house during the year was 704, being 118 less than during the preceding year. The average daily number of patients was 43, and the average period of residence 22 days. In addition to the in-door patients 15,000 out-patients attended the infirmary during the past year. The ordinary income for the year now reported on—£21,902 14*s.* 4*d.*, as compared with £21,540 14*s.* 2*d.* for the preceding year—shows an increase, notwithstanding the great depression which has existed during the year, of £362 0*s.* 2*d.* This increase is gratifying and encouraging. The students' fees amounted to £3443 12*s.*, and for the year ended Oct. 1st, 1880, they were £4179 8*s.*, and in the previous year £2643 13*s.* The extraordinary income—that is, receipts from donations and legacies above £100—amounted to £6572 3*s.* 7*d.*, as compared with £18,255 18*s.* 6*d.* for the preceding year, showing a decrease of £11,683 14*s.* 11*d.* The ordinary expenditure of the infirmary for the past year was £31,720 16*s.* 8*d.*, as against £27,818 11*s.* 4*d.* for the preceding year, showing an excess of £3902 5*s.* 4*d.* The increased expenditure was due to the large increase (431) in the number of patients treated during the year, and to the maintenance of a separate establishment for infectious diseases. The more serious increase was due to the latter source. The report then goes on to say:—"If a separate institution is to be maintained—and maintained in efficiency as hitherto—the public must come forward with increased liberality. It is right to mention, in connexion with this, that in other large towns the charge of fever patients is undertaken by the municipal authorities under the Public Health Act, and the expense of treatment defrayed from the local rates. Whether the contributors are prepared to urge on the municipal authorities of this city the propriety of following a similar course, or will by increased subscriptions enable the managers to maintain as at present a separate and expensive establishment for the treatment of infectious diseases, is a matter for their serious consideration. In order that adequate provision may in the meantime be made for fever patients, the managers have taken steps for putting into proper condition the portion of the old infirmary buildings reserved for such cases. The alterations necessary are now nearly completed, and the buildings will, it is expected, be ready for the transference of the patients early in the year." During the past year the managers have paid £13,430 1*s.* 4*d.* further, on account of the cost of the new infirmary. A large debt is still due to the bank in connexion with the erection of the new buildings, against which has been placed the price realised from the old infirmary.

The good work which may be done in the new infirmary cannot be over-estimated; but that it may be accomplished the institution must be more liberally supported than hitherto. Encouraged by the liberality of the friends of the institution in past years, the managers feel that they have only to inform the contributors of their necessities, in order that the funds may be forthcoming. The Lord Provost, in terms of the charter of the infirmary, moved that the report be remitted to a committee for consideration, and that an adjourned meeting be held a fortnight hence to receive the report of the committee. This was agreed to. The Lord Provost proposed the re-election of the following managers, which was also agreed to:—Mr. Robert Bryson, Mr. Wm. J. Ford, Dr. Henry D. Littlejohn, Mr. Edmund Baxter, Mr. Edward L. I. Blyth, and Mr. Adam Gillies Smith. Dr. Russell, in moving a vote of thanks to the Lord Provost for presiding, took the opportunity also of tendering thanks to the managers for the very successful way in which the infirmary was managed, remarking that the hospital had hitherto been managed, not only with efficiency and economy, but with such dignity as made them all proud of the infirmary. The Lord Provost, in replying, said the managers were in a great measure largely dependent on legacies for maintaining the institution. These had been less than usual this year; but a very pleasant matter had arisen since the report was prepared. In the course of a short time the managers expected to receive £12,000 from the estate of the late Dr. Hunter. Had this come a few days sooner last year's accounts would have looked much better than they did.

GLASGOW.

(From our own Correspondent.)

THE profession in Glasgow has recently lost by death a well-known member in Mr. John Reid. Mr. Reid was a man of marked individuality, having strong sympathies and strong convictions; he expressed them readily and fearlessly, both with tongue and pen. He will be much missed at the meetings of the Medico-Chirurgical Society, where his vigorous speech and ultra-Conservatism threw interest into many a debate.

Our Police Ambulance Classes are to be conducted by Dr. W. McEwen, police surgeon, with the assistance and advice of Professor George Buchanan (who has made himself prominent in this movement), and of Dr. Irvine. Dr. McEwen's first class is to consist of twelve members of the force.

The "Combe Trust" series of health lectures, managed by our local Young Men's Christian Association, was brought to a close by an able discourse on Insanity, given by Dr. Yellowlees. These lectures have been very well attended, and are now printed and sold for a penny each. One of them, that addressed "to women only," and dealing with such subjects as menstruation, pregnancy, &c., had to be published under the auspices of the Young *Women's* Christian Association, to meet the prudish objections of some weak friends. It is being largely bought, mainly by young women, and was one of the best attended lectures of the whole course.

The Western Medical School is prospering. At its annual dinner the chairman announced that there were on its roll twenty-eight students. This shows a marked advance on last year.

The great medical charities of Glasgow are in distress again. The Western Infirmary having doubled its accommodation, is more in need of money than ever. The Royal is no less than £10,000 behind this year, and its directors have issued a strong appeal to the public for aid. The annual report of this institution is looked for with some interest. The impecunious condition of these infirmaries seems to have brought the Southern Hospital scheme to a standstill, in the meantime at any rate.

IRELAND.

(From our own Correspondent.)

ON the 26th inst. the Council of the Royal College of Surgeons will proceed to appoint a Professor of Practical and Descriptive Anatomy, in the room of Professor Bevan, deceased. The gentleman elected must conduct a class in histology, and devote his entire time to the duties of the office. The selection will have to be made from a limited circle, as there is a comparatively small number of competent medical men who will be willing to forego all other emoluments, which is a necessary condition for the appointment.

A promising young physician, Dr. Reuben J. Harvey, of Dublin, died last week of typhus fever, after a short illness. The deceased contracted the disease while acting as one of the visiting physicians to the Cork-street Fever Hospital. Dr. Harvey was a lecturer on Physiology in the Carmichael School of Medicine, and recently vacated the post of assistant-physician to the Richmond Hospital in order to devote more of his time to physiological research. He was a graduate in medicine of the University of Dublin, an ex-medical scholar and senior moderator, a member of the Royal Irish Academy, and in 1879 was elected a Fellow of the College of Physicians in Ireland. Dr. Harvey leaves a widow and family to mourn his untimely death.

Mr. Thomas Strain, a citizen of Belfast, has on several occasions been fined for refusing to permit his child to be vaccinated, and on the 15th ult. he was again summoned at the instance of the Belfast Guardians for a similar offence. On this occasion, however, the magistrate dismissed the case with costs against the guardians. There is no right of appeal against this decision, which can only be reviewed in the Court of Queen's Bench, and is a matter for the consideration of the Local Government Board. It is singular that the magistrate in question last May fined Mr. Strain 20s. for refusing to have his child vaccinated. The action of the Local Government Board is awaited with anxiety, more especially as small-pox is gradually spreading in Belfast. During Christmas week twenty-one additional cases were admitted into the Belfast workhouse, while five were discharged, and two died, leaving ninety-six under treatment.

The committee of the proposed Convalescent Home for Dublin have finally determined to accept the offer of the Governors of the Cork-street Fever Hospital, and will hand over the subscriptions obtained for the purpose of increasing in that institution the accommodation for patients recovering from infectious diseases.

Measles is rather prevalent among the children in the North Dublin Union Workhouse, and last week eighteen deaths took place from this affection.

The Royal assent has been given to the Statutes of the Royal University of Ireland; and it is probable that a meeting of the Senate will shortly be held to elect examiners for the First University Examination, which it is believed will take place in April.

An election for a medical officer to the North Dublin Union, at a salary of £150 per annum, will take place on Wednesday the 25th inst., when the Guardians will select a successor to Dr. Kenny, who has been removed by a sealed order of the Local Government Board.

PARIS.

(From our own Correspondent.)

IN the current number of the *Gazette Hebdomadaire* Dr. Barth contributes the last instalment of an interesting memoir on the treatment of adynamic pneumonia by hypodermic injections of ether. Of thirty-five patients who were admitted into La Pitié hospital under his care, the larger number recovered spontaneously or under ordinary treatment; and the subcutaneous injection of ether was only adopted when all other remedies had failed. Fourteen cases, all of the most serious character, are related at full length; and in eleven of these the patients recovered. The following will serve as an example:—A washerwoman, aged thirty-nine, was admitted into La Pitié under the care of Professor Brouardel on the 3rd of November. She had been suffering from typhoid fever for three weeks, and had frequently been delirious. There were headache, cough, and constant diarrhœa. The tongue was dry, the belly distended, and the bases of both lungs were congested. The morning temperature was 39°; the evening, 40° Centigrade. On the 10th the general condition was very serious: the face pinched, the extremities cold, the body covered with perspiration, great prostration of strength, extreme distension of the belly. Tongue dry; temperature 37·2° C. In the lower half of the right lung and behind there was marked dulness, tubular souffle, and fine crepitant rhonchus. A blister was applied and ether injected to the amount of two grammes a day. On the 12th the tongue was moist, the dulness and souffle had almost disappeared, and the diarrhœa had stopped. On the 17th the injections were discontinued, and on the 28th the patient was convalescent. Dr. Barth has also obtained good results from this method in puerperal fever, typhoid, and other affections, and another physician, Dr. Dupuy, has practised it with success in the algid period of cholera.

At the Société de Biologie M. Dumontpallier has recently made a series of communications on metalloscopy and cognate practices, which go far beyond anything hitherto published on the subject. He asserts that one of the patients in his service, when hypnotised and prepared for experiment by the application of a silver brass plate on the left side of the forehead, can be made to contract certain muscles by the operator simply looking at them. In order to show that the contraction is really due to what he terms ocular influx (a form, no doubt, of the lately resuscitated neuric force), a pane of glass is interposed between experimenter and subject, and instead of looking directly at the muscle its image is stared at in a mirror. The ocular influx thus passes through the glass and is reflected by the mirror to the muscle, which immediately enters into contraction. If a drop of water be allowed to fall upon the gastrocnemius of this patient, it at once contracts, and a second drop produces its resolution. Finally, and marvellous to relate, if, when this girl is awakening from her hypnotic sleep, M. Dumontpallier should look at the region of her left third frontal circumvolution, or should point at it with his finger, she becomes aphasic; a second look or gesture restoring speech. A glance at the ascending frontal causes a movement in the arm, and so on.

Obituary.

JAMES OLDHAM, F.R.C.S.

WE have to record the death of Mr. James Oldham of Brighton and Hayward's Heath. Mr. Oldham was residing at the latter place at the time of his death. He had retired to his private estate there for more than a year. He was born on the 17th January, 1817; died December 26th, 1881. With untiring energy and devotion Mr. Oldham practised his profession in Brighton from the year 1842 until his retirement about the time named, October, 1880. His education was private. He was apprenticed to Dr. Pye-Smith, the father of Dr. Pye-Smith of Guy's; entered at Guy's October, 1838, and was dresser to Mr. Aston Key. Though not of a strong frame or constitution, Mr. Oldham had nevertheless been able to do the work of a very large private practice, probably one of the largest in the country; and, it may certainly be added, to the great advantage and satisfaction of all who had the privilege of his care.

The profession of medicine will never lose the respect due to it from the public whilst maintained by such good services, and rendered with such delicate feeling and high sense of honour, as are daily afforded by gentlemen in general practice of the type and character of Mr. Oldham. Happily, he was but one of a large class to be found in distinguished positions all over the country. One of his younger colleagues in Brighton writes thus of him:—"My acquaintance with him was of a personal kind from my early boyhood, and all the time he was as kind to me as an elder brother, always taking an affectionate interest in my welfare, and winning my love and esteem."

Without being scientific, or learned in the scientific

shibboleths of the time, he had that practical acquaintance with disease which is of more immediate value to the sick; and those who knew him intimately through his long and arduous practice will feel how faithfully and adequately he set before him and attained the proper aims of medicine, whether for alleviation or for cure. This testimony will find a ready echo amongst Mr. Oldham's many friends and distinguished patients.

Mr. Oldham was very generous. He purchased and supported a coffee-house tavern, and at Hayward's Heath St. Christopher's Home for Sick Children was almost entirely supported by him. He was a liberal contributor to the Church and schools in his neighbourhood, and in these and many other ways gave largely of that fortune which he had accumulated from his deservedly successful practice.

Mr. Oldham married, in 1844, Anna, second daughter of Thomas Brame Oldfield, Esq., of Champion Hill, Surrey. He leaves three sons and two daughters. Mr. Oldham's death, at the age of sixty-five, though early, was not premature. For some years his health had been failing, he had gradually become anæmic, with enfeebled circulation and albuminuria. During his long and tedious final illness, he had the continued and affectionate services of his friend Dr. Byass, of Cuckfield. He was one of the founders of the Brighton and Sussex Medical Chirurgical Society, thirty-five years ago, which now numbers eighty-eight members.

WILLIAM CARRUTHERS, M.R.C.S., L.S.A.

MR. CARRUTHERS was the third son of the Rev. Robert Carruthers, M.A., Master of the Grammar School and Curate in Charge of Holbeach, Lincolnshire. He was born in August, 1812, and was educated at Christ's Hospital, London. At an early age he was put under professional training with Mr. John Page, surgeon, Kirton, Lincolnshire, and subsequently with Mr. Whitmore of London. These gentlemen in great measure helped to mould the character of one who in after-life was, besides being a very skilful surgeon, an accomplished general practitioner and a man of honour and integrity. He continued his professional studies at King's College and St. George's Hospitals, London. At the latter school he formed a close friendship with the celebrated Dr. Lee and Mr. Samuel Lane, surgeon, for whom he acted as prosector. In 1839 he obtained the L.S.A.; and in 1840 the M.R.C.S. He was for some time house-surgeon to the Chester Infirmary; and first practised at Runcorn and at Heatly Heath, near Lynn; and finally settled at Halton, near Runcorn, Cheshire, succeeding to the practice of the late Mr. Lax in 1844. He held numerous appointments in the district, and his services were in constant request and greatly appreciated; and during the latter part of his life his advice was frequently sought in consultation with the neighbouring practitioners. He conducted a very large practice for the very long period of thirty-seven years. He took but few holidays. With that singleness of purpose which characterises our profession, his great aim and object seemed to be constantly ministering to the sick; and it is only within the last two or three years that he relaxed the terrible strain on his constitution, which was at its best never very robust.

The deceased had numerous tokens presented to him during his lifetime of the great esteem in which he was held in the district. It may be truly said of Mr. Carruthers that he died in harness; for it was only on the Sunday preceding his death that he walked to Runcorn, a distance of a mile and a half, to see some patients; and it was on the return journey, in a drenching rain, that he caught the cold which was so soon to cut short his useful life, and deprive the profession of one of its wisest, best known, and most respected members in the district. Early on Friday morning alarming chest symptoms appeared; and on Monday afternoon, with Christian resignation, and conscious to the end, he peacefully passed away—dying in the arms of his son, who attended him with constant assiduity during his brief illness.

DR. J. F. STEVENSON, physician to the Birkenhead Borough Hospital, who about three years since was made a justice of the peace for the borough, was on January 2nd sworn in as a county magistrate.

Medical News.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—The following gentlemen passed the Primary Examination in Anatomy and Physiology at meetings of the Board of Examiners on Tuesday and Wednesday last:—

Thomas Underwood, G. Hart, and G. R. Pigg, Owens College, Manchester; W. M. Bristow, Henry Lloyd, A. J. Charlick, T. W. Twinem, and R. H. Carrey, Liverpool; H. S. Jones, R. F. T. Perkins, and F. A. Bennett, Birmingham; L. J. Bateman, George Parker, A. Keightley, and H. P. Tayler, Cambridge; C. Boyd, Dublin; William Atkinson, Galway and Sheffield; Thos. Sinclair, Belfast; G. H. Do'ath, Guy's Hospital; H. R. Codd, University College; T. A. Dagg, St. Bartholomew's Hospital; A. G. Hanson, London Hospital; R. Beresford, Sheffield and Belfast; H. M. Hughes and Joseph Hick, Leeds; C. J. Wilkinson, St. Thomas's Hospital; W. P. Davis, St. George's Hospital; H. M. L. Dean and James Young, Owens College; D. R. Wadia, Bombay.

For this examination 179 candidates presented themselves, against 146 at the corresponding period last year, showing an increase of 33. Of the 179 candidates, no less than 68 had been up before, 11 made their appearance for the third time, 4 for the fourth time, and 1 for the sixth time. The primary examination will not be brought to a close until next week.

APOTHECARIES' HALL.—The following gentlemen passed their examination in the Science and Practice of Medicine, and received certificates to practise, on Dec. 29th:—

Fielden, William Eckett, Walthamstow.
Holdsworth, William Thomas, Handsworth.
Hoole, John, Hornsey-road.
Moore, Robert Carmichael, Belfast.
Tarleton, Edward Eustace, Cheddar, Somerset.

The following gentlemen also on the same day passed the Primary Professional Examination:—

Frederick Victor Duckworth, Guy's Hospital; William Anthony Nutt, London Hospital.

AN enlargement of the Shropshire County Lunatic Asylum is said to be contemplated.

A SANITARY Exhibition is to be held this year in Berlin under the patronage of the Empress of Germany and the Crown Prince. The programme put forward appears very complete.

VOLUNTEER AMBULANCE DEPARTMENT, A.M.D.—We understand that the Official Inspection of the present Ambulance Class will take place at the Guildhall on Wednesday evening, January 18th, at 7.30. The Right Honourable the Lord Mayor will preside.

INFIRMARY SATURDAY MOVEMENT, CARDIFF.—The amount collected at the various works in the town and neighbourhood, in connexion with this movement, has amounted to £709 12*s.*, which, after paying expenses, has left a clear balance of £643 7*s.*

AT the last quarterly meeting of the board of trustees of the Bristol Royal Infirmary, leave was given for the sale of £2500 stock. A hope was, however, expressed that, in consequence of the results of the recent appeal for subscriptions and other favourable signs, the need for taking this step might yet be averted.

LONDON TEMPERANCE HOSPITAL.—The Middlesex District Lodge of the Independent Order of Good Templars have resolved to complete the contribution of £1000 for the establishment of a Good Templars' ward in the new London Temperance Hospital in the Hampstead-road. About £850 has already been raised, and the lodges are to contribute the balance without delay.

FIRTH COLLEGE, SHEFFIELD.—The number of students who have entered the Chemical Laboratory of the College this session has, we learn, been so great that the present accommodation has been quite insufficient. The Council, therefore, decided at their last meeting to erect working benches for sixteen more students. The University of Edinburgh has recently recognised Dr. Carnelley Professor of Chemistry in Firth College, as a teacher of medicine in Sheffield, whose lectures on chemistry and course of instruction in practical chemistry will qualify for graduation in medicine in that university. The lectures on Chemistry and Laboratory practice at Firth College have also been recognised by the Royal College of Surgeons and the Royal College of Physicians.

A BUST in marble of Dr. G. A. Otis, U.S.A., has been placed in the Army Medical Museum by his brother officers.

HOSPITAL SUNDAY IN NEW YORK.—The custom of collecting money in churches on one day in the year in aid of the hospitals, which was introduced into New York from London, is gaining ground on the other side of the Atlantic. Hospital Sunday in New York was held on Christmas Day, and the collection amounted to 44,000 dols. In 1879, when the movement was first started, the amount realised was only 26,000 dols.

LONDON HOSPITAL.—On Monday, January 2nd, a ball was given to the matron and nursing staff of the London Hospital by the resident medical officers. Being the first occasion on which a public entertainment of this kind has occurred at the London Hospital, it is pleasing to observe that it proved a great success. Amongst those present were Sir Rose Robinson, Col. Keating, Mr. and Mrs. Nixon, Dr. and Mrs. Palfrey, Mr. Walter Rivington, and Dr. Stephen Mackenzie. We cannot but think that occasional festivities of this character, especially at this season of the year, must diffuse a healthy stimulus amongst those engaged in hospital work.

BOOKS ETC. RECEIVED.

BAILLIÈRE, TINDALL, & COX, London.

Schematic Anatomy, or Diagrams, Tables, and Notes treating of the Association and Systematic Arrangement of Structural Details of Human Anatomy. By William P. Mears, M.B. pp. 200. With numerous Diagrams.

Consumption: a Reinvestigation of its Causes. By C. W. De Lacy Evans, M.R.C.S. pp. 78.

CHURCHILL, J. & A., London.

Leprosy in British Guiana: an Account of West Indian Leprosy. By John D. Hillis, F.R.C.S., M.R.I.A. pp. 204. With Illustrations.

Diseases and Injuries of the Eye. By J. R. Wolfe, M.D.

Year-book of Pharmacy, 1881. With the Transactions of the British Pharmaceutical Conference, held at York, August, 1881. pp. 560.

HOUGHTON, MIFLIN, & CO., Boston; TRÜBNER & CO., London.

The Diagnosis and Treatment of Diseases of the Eye. By H. W. Williams, M.D. pp. 465. With Illustrations.

KIMPTON, H., London.

The Mother's Guide in the Management and Feeding of Infants. By John M. Keating, M.D. pp. 118.

KOLCKMANN, J. W., London.

Transactions of the International Medical Congress, Seventh Session, held in London, August 2nd to 9th, 1881. Prepared for publication, under the direction of the Executive Committee, by Sir Wm. Mac Cormac, Hon. Secretary-General, assisted by G. H. Makins, F.R.C.S., Under-Secretary, and the Secretaries of the Sections. In 4 vols. Vols. I. and III. pp. 518—660.

LEWIS, H. K., London.

A Practical Treatise on Materia Medica and Therapeutics. By Roberts Bartholow, M.D. Fourth Edition, revised and enlarged. pp. 662.

A Treatise on the Diseases of Infancy and Childhood. By J. Lewis Smith, M.D. Fifth Edition, thoroughly revised. pp. 836. With Illustrations.

The Science and Art of Midwifery. By W. T. Lusk, A.M., M.D. pp. 685. With numerous Illustrations.

The Applied Anatomy of the Nervous System. By A. I. Ranney, A.M., M.D. pp. 500. With numerous Illustrations.

LONDON NATIONAL TEMPERANCE PUBLICATION DEPÔT.

The National Temperance League's Annual for 1882. pp. 191.

LONGMANS, GREEN, & CO., London.

The Origin of Civilisation and the Primitive Condition of Man. By Sir John Lubbock, Bart., M.P., F.R.S. Fourth Edition, with numerous Additions. pp. 548. Illustrated.

MACMILLAN & CO., London.

A Treatise on Chemistry. By H. E. Roscoe, F.R.S., and C. Schorlemmer, F.R.S. Vol. III.: The Chemistry of the Hydrocarbons and their Derivatives; or Organic Chemistry. Part I. pp. 724. Illustrated.

On Teaching; its Ends and Means. By H. Calderwood, LL.D., F.R.S.E. Third Edition. pp. 126.

Sir Thomas Browne's Religio Medici. Edited by W. A. Greenhill, M.D.Oxon. pp. 388.

RENSHAW, H., London.

Elements of Pharmacy, Materia Medica, and Therapeutics. By Wm. Whitla, M.D. pp. 522. With Lithograph and Woodcuts.

SMITH, ELDER, & CO., London.

Scrofula and its Gland Diseases. By Frederick Treves, F.R.C.S.E. pp. 205. With Five Plates.

SPON, E. & F. N., London.

Experimental Researches into the Properties and Motions of Fluids. By Wm. Ford Stanley. pp. 550. With numerous Illustrations.

STANFORD, E., London.

The Water-supply of England and Wales. By Chas. E. de Rance, Assoc. Inst., C.E., F.G.S. pp. 622. With Coloured Maps.

WARD, MARCUS, & CO., London.

Only a Twelvemonth, or the County Asylum. pp. 186.

Good Words, Sunday Magazine (with extra Christmas Number), December (Isbister and Co.).—The Smoke Difficulty Conquered; by F. Edwards, jun. (Longmans).—The North American Review, December.—Health Lectures for the People (Macniven and Wallace, Edinburgh).—Rudolf Virchow; by A. Jacobi, M.D.—Contribution à la Géographie Médicale; par le Dr. A. F. Ekland.—The Ingoldsby Legends; illustrated by Cruikshank, Leech, and Tenniel; People's Edition, 6d.—North American Review.—On Cooking and Heating by Gas; by Wm. Denny, F.R.S.E.—Chronic Club-foot, successfully Treated without Tenotomy by continuous Extension and Stretching; by Dr. J. S. Green.—Index Medicus, Vol. III., No. 2.—On Artificial Respiration in Still-born Children.—Comparison between the Scoliotic and Obliquely contracted (Naegele) Pelves.—Case of Delivery through a Scoliotic Pelvis.—On the Pain in Pelvic Cancer and its Relief by Morphia, Illustrated by fifty Cases; by F. H. Champneys, M.A., M.B.Oxon., &c.—Cross-legged Progression, the Result of Double Hip Anchylosis; by R. C. Lucas, B.S., M.B.Lond.—Registration and Sanitation, their Value; by Dr. H. F. Campbell.—Fraser's Magazine, Jan.—The Boy's Own Paper, the Girl's Own Paper, Leisure Hour, Sunday at Home (Religious Tract Society).—Good Words, Sunday Magazine (Isbister and Co.).—Treatment of Varicocele by Excision of Redundant Scrotum; by Dr. M. H. Henry (Vail, New York). The Antiquarian Magazine and Bibliographer; edited by Ed. Walford, M.A. (Reeves, Fleet-street).—Early Closing Association's Annual Report.—Calvert's Mechanics' Almanack.—The Prophylactic and Therapeutic Value of Quinine in Gynetic and Obstetric Practice; by Dr. H. F. Campbell.—Malaria v. Recognisable Climatic Influences; by Dep. Surg. Gen. W. J. Moore.—Adenoma Tubulato del Fegato; per il Dottori V. Brigidi e G. Banti.—Contributo allo Studio delle Anemie Progressive.—Studio Anatomo-Patologico sull' Ipertrofia Generale delle Mammelle; del Dott. G. Banti.—On the Variations of Relative Humidity and Thermometric Dryness of the Air; by G. M. Whipple, B.Sc., &c.—Journal of Science.—Birmingham Medical Review, January.

Medical Appointments.

Intimations for this column must be sent DIRECT *to the Office of* THE LANCET *before 9 o'clock on Thursday Morning, at the latest.*

BERNAYS, HERBERT L., M.R.C.S., L.S.A.Lond., has been appointed Medical Officer of Health for Charlton, vice Finch, deceased.

BROWN, MARTIN L., M.B., has been appointed Assistant Medical Officer of the Male Department of the Middlesex County Lunatic Asylum, Colney Hatch, vice W. J. Seward, M.B.Lond., appointed Medical Superintendent.

CANE, FRANCIS E., L.R.C.P.Ed., L.R.C.S.Ed., has been appointed Surgeon to the Anchor line of Transatlantic steamers.

CURRIE, JOHN, M.D.Glas., L.R.C.S.Ed., has been appointed Medical Officer for the Berry Pomeroy District of the Totnes Union, vice Chitty, resigned.

DALTON, C. GERALD, M.R.C.S., L.S.A.Lond., has been appointed Medical Officer for the Second and the Eleventh Districts of the Lincoln Union.

DAVIES, D. ARTHUR, M.B.Lond., M.R.C.S., has been appointed Physician to the Swansea Hospital.

DREWITT, F. G. DAWTREY, M.B.Oxon., M.R.C.P.Lond., M.R.C.S., has been appointed Assistant Physician to the Victoria Hospital for Sick Children, vice Allchin, resigned.

FITZGERALD, GERALD H., M.D., has been elected Medical Officer to the Workhouse and District of Ponteland.

GUEST, ELLIS S., M.R.C.S., L.S.A.Lond., has been appointed Honorary Surgeon to the Chorlton-on-Medlock Dispensary.

HARRISON, GEORGE, L.R.C.P.Ed., L.R.C.S.Ed., has been appointed Medical Officer for the City District and the Workhouse of the Chester Union.

HEHNER, OTTO, F.C.S., has been appointed Public Analyst for the Southern Division of Derbyshire.

LANE, W. ARBUTHNOT, M.R.C.S., has been appointed House-Surgeon to the Victoria Hospital for Sick Children, vice Chaffey, resigned.

MACLEOD, M. D., M.B., Assistant Superintendent, Cumberland and Westmoreland Asylum, has been appointed Medical Superintendent of the East Riding Asylum, Beverley.

RATTON, JOHN M. DE VERDE, L.R.C.P.Ed., L.R.C.S.Ed., has been appointed by the Colonial Government, Medical Officer to the Third District in the Civil Service of St. Kitts.

ROW, F. EVERARD, M.R.C.S., L.R.C.P.Lond., has been appointed Surgeon to the Clowance and St. John's District in the Parish of Stoke Damerel, Devonport.

SHEPPARD, CHARLES E., M.D.Lond., has been appointed Resident Assistant Physician and Medical Registrar to St. Thomas's Hospital, vice G. Gulliver, M.A., M.B., appointed Assistant Physician.

WANKLYN, J. ALFRED, F.C.S., has been reappointed Public Analyst for the Borough of Buckingham.

WHITCOMBE, EDMUND BANCKS, M.R.C.S., Medical Superintendent, East Riding Asylum, Beverley, has been appointed Medical Superintendent of the Borough Asylum, Birmingham.

WHITCOMBE, MR. P. P., has been appointed Assistant House-Surgeon to the London Lock Hospital, vice Tindal King, M.R.C.S., L.S.A.L., resigned.

Births, Marriages, and Deaths.

BIRTHS.

CLOUSTON.—On the 27th ult., at Marlborough-road, Gunnersbury, the wife of C. S. Clouston, M.D., of a daughter.

HORNER.—On the 1st inst., at Tonbridge, Kent, the wife of Arthur Claypon Horner, M.R.C.S., of a son.

SCHOFIELD.—On April 28th, 1881, at T'ai-Yuen-Fu, the wife of R. H. A. Schofield, M.A., F.R.C.S., of a son.

STEWART.—On the 25th ult., at Essex-villas, High-road, Lee, the wife of Frederick George Stewart, M.R.C.S., of a daughter.

TOMLINSON.—On the 31st ult., at Freshwater, Isle of Wight, the wife of Surgeon-Major W. Winslow Tomlinson, A.M.D., of a daughter.

VENOUR.—On November 29th, at Meerut, Bengal, the wife of Surgeon-Major Venour, Army Medical Department, King's Dragoon Guards, of a daughter.

MARRIAGES.

ELLIS—WEBB.—On the 3rd inst., at Christ Church, Mayfair, by the Rev. W. Cardall, Vicar, Heber D. Ellis, M.D., of 7, Howard-square, Eastbourne, to Frances Audrey, eldest daughter of the late Rev. Robert Holden Webb, M.A., Rector of Essendon, Herts.

LANGDON—WOODS.—On the 30th ult., at St. Luke's, Holloway, London, by the Rev. Reynold Walters, John Winkley Langdon, M.R.C.S., &c., of Winkley-square, Preston, to Annie Nightingdale Woods, of The Colonnade, Preston.

PEDLEY—WILKINSON.—On the 1st ult., at the Cathedral, Calcutta, Thomas Franklin Pedley, M.D., M.R.C.S., eldest son of George Pedley, of the Borough and Camberwell, to Mary Hall (Minnie), daughter of the late John Randolph Wilkinson, of Belfast, and great-niece of Mrs. Kennerley, of Hampstead.

DEATHS.

BREACH.—On the 28th ult., at Aston Upthorpe, Wallingford, John Breach, M.R.C.S., L.S.A.Lond., aged 68.

BROOKES.—On the 29th ult., at 276, Kennington-road, S.E., Ada Jessie, the beloved wife of Frederick William Brookes, M.R.C.S., of 137, Westminster-bridge-road, third daughter of the late G. Smith, Esq., of Kennington, aged 27.

DASHWOOD.—On the 28th ult., at Putney, Jarrett Dashwood, M.R.C.S., formerly of Wellington-street, Southwark, aged 78.

GAULTER.—On the 26th ult., at Church-terrace, Queen's-road, Battersea, Emily, widow of Thomas Coke Gaulter, M.D., late of Chelsea Hospital.

GORE.—On the 2nd inst., at Tunbridge-Wells, Henry John Gore, M.D., aged 35.

HARVEY.—On the 29th ult., of typhus fever, at Upper Merrion-street, Dublin, Reuben J. Harvey, M.D., M.Ch.Dub., Physician to Cork-street Fever Hospital.

PRATER.—On the 2nd inst., at Maison-Dieu-road, Dover, Augustus Prater, M.D., late of Woolwich, aged 70.

SWYER.—On the 31st ult., at his residence, 25, Mile-end-road, after a few hours' illness, R. E. Swyer, Esq., M.D., aged 59.

N.B.—*A fee of 5s. is charged for the insertion of Notices of Births, Marriages, and Deaths.*

Medical Diary for the ensuing Week.

Monday, Jan. 9.

ROYAL LONDON OPHTHALMIC HOSPITAL, MOORFIELDS.—Operations, 10½ A.M. each day, and at the same hour.

ROYAL WESTMINSTER OPHTHALMIC HOSPITAL.—Operations, 1½ P.M. each day, and at the same hour.

METROPOLITAN FREE HOSPITAL.—Operations, 2 P.M.

ROYAL ORTHOPÆDIC HOSPITAL.—Operations, 2 P.M.

ST. MARK'S HOSPITAL.—Operations, 2 P.M.; on Tuesday, 9 A.M.

Tuesday, Jan. 10.

GUY'S HOSPITAL.—Operations, 1½ P.M., and on Friday at the same hour.

WESTMINSTER HOSPITAL.—Operations, 2 P.M.

WEST LONDON HOSPITAL.—Operations, 2 P.M.

ANTHROPOLOGICAL INSTITUTE OF GREAT BRITAIN AND IRELAND.—8 P.M. Major-General Pitt-Rivers, "On the Entrenchments of the Yorkshire Wolds, and Excavations in the Earthwork called Danes' Dyke at Flamboro'." With Diagrams and Illustrations.—Mr. J. R. Mortimer, "On the Discovery of Ancient Dwellings on the Yorkshire Wolds."

ROYAL MEDICAL AND CHIRURGICAL SOCIETY.—8.30 P.M. Dr. Charles Creighton, "On Three Cases of Tumour arising from Skin Glands in the Dog, showing the connexion between disorders of the secreting structure and functions and cancerous invasion of the connective tissue."—Mr. T. M. Girdlestone, "On the Surgical Uses of Kangaroo Tendons."

Wednesday, Jan. 11.

NATIONAL ORTHOPÆDIC HOSPITAL.—Operations, 10 A.M.

MIDDLESEX HOSPITAL.—Operations, 1 P.M.

ST. BARTHOLOMEW'S HOSPITAL.—Operations, 1½ P.M., and on Saturday at the same hour.

ST. THOMAS'S HOSPITAL.—Operations, 1½ P.M., and on Saturday at the same hour.

ST. MARY'S HOSPITAL.—Operations, 1½ P.M.

LONDON HOSPITAL.—Operations, 2 P.M., and on Thursday and Saturday at the same hour.

GREAT NORTHERN HOSPITAL.—Operations, 2 P.M.

UNIVERSITY COLLEGE HOSPITAL.—Operations, 2 P.M., and on Saturday at the same hour.—Skin Department.—1.45 P.M., and on Saturday at 9.15 A.M.

SAMARITAN FREE HOSPITAL FOR WOMEN AND CHILDREN.—Operations, 2½ P.M.

HUNTERIAN SOCIETY.—7.30 P.M. Council Meeting.—8 P.M. Dr. Pye-Smith, "On the Pathological Significance of Pus in the Urine."

OBSTETRICAL SOCIETY OF LONDON.—8 P.M. Specimens will be shown.—Adjourned Discussion on Dr. Godson's Paper on Spasmodic Dysmenorrhœa and Sterility, and its Treatment by Graduated Metallic Bougies.—Dr. Playfair, "On Notes on Trachelo-raphé, or Emmet's Operation."

Thursday, Jan. 12.

ST. GEORGE'S HOSPITAL.—Operations, 1 P.M.

ST. BARTHOLOMEW'S HOSPITAL.—1½ P.M. Surgical Consultations.

CHARING-CROSS HOSPITAL.—Operations, 2 P.M.

CENTRAL LONDON OPHTHALMIC HOSPITAL.—Operations, 2 P.M., and on Friday at the same hour.

HOSPITAL FOR WOMEN, SOHO-SQUARE.—Operations, 2 P.M.

NORTH-WEST LONDON HOSPITAL.—Operations, 2½ P.M.

ABERNETHIAN SOCIETY (St. Bartholomew's Hospital).—8 P.M. Mr. Kendall, "On Curiosities of a Shilling Practice."

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.—8½ P.M. Dr. Stephen Mackenzie, "On a Case of Acute Vascular Disease, with Retinal Hæmorrhages."—Mr. Jas. E. Adams: (1) "On a Case of Epithelioma of Cornea, with Microscopical Specimens;" (2) "On a Case of an Exceptional Degree of Spasm of Accommodation."—Mr. G. E. Wherry: (1) "On a Case of Paralysis of Fifth and Facial Nerves, with Corneal Opacity, in an Infant;" (2) "On a Case of Chancre on the Palpebral Conjunctiva."—Mr. McHardy: (1) "On an Improved Form of Stevens' Registering Perimeter;" (2) "On a Specimen of Black Cataract."—Dr. Walter Edmunds, "On a Case of Suppurative Panophthalmitis after Ligature of Common Carotid."—Mr. Lawford: (1) "On a Case of Optic Neuritis following Purpura;" (2) "On a Case of Unusual Gunshot Injury of the Eye."—Mr. Nettleship, "Note on a Case of Diabetic Cataract."—Living Specimens at 8 o'clock.

Friday, Jan. 13.

ST. GEORGE'S HOSPITAL.—Ophthalmic Operations, 1½ P.M.

ST. THOMAS'S HOSPITAL.—Ophthalmic Operations, 2 P.M.

ROYAL SOUTH LONDON OPHTHALMIC HOSPITAL.—Operations, 2 P.M.

KING'S COLLEGE HOSPITAL.—Operations, 2 P.M.

CLINICAL SOCIETY OF LONDON.—Annual Meeting.—Election of Officers.—Adjourned Discussion on Cases of Myxœdema.—Mr. W. H. Kesteven, "On a Case of Unilateral Xanthopsia."—Cases of Renal Calculus removed by operation by Mr. Beck, Mr. Butlin, Dr. Whipham and Mr. Haward.—Dr. S. Mackenzie will Exhibit a Case of Lupus psoriasis.

Saturday, Jan. 14.

ROYAL FREE HOSPITAL.—Operations, 2 P.M.

METEOROLOGICAL READINGS.

(Taken daily at 5.30 a.m. by Steward's Instruments.)

THE LANCET OFFICE, Jan. 5th, 1882.

Date.	Barometer reduced to Sea Level, and 32° F.	Direction of Wind.	Dry Bulb	Wet Bulb	Solar Radiation in Vacuo	Max. Temp Shade	Min. Temp	Rain fall.	Remarks at 8.30 A.M.
Dec. 30	30·03	S.W.	45	43	..	46	41	..	Overcast
,, 31	29·93	S.W.	45	45	..	46	43	..	Overcast
Jan. 1	29·90	W.	45	44	..	50	41	..	Cloudy
,, 2	29·81	W.	46	44	..	52	36	·20	Cloudy
,, 3	29·22	W.	49	47	..	50	47	·24	Cloudy
,, 4	29·85	W.	58	56	..	47	36	..	Foggy
,, 5	29·72	W.	52	51	..	52	34	·09	Overcast

Notes, Short Comments, and Answers to Correspondents.

It is especially requested that early intelligence of local events having a medical interest, or which it is desirable to bring under the notice of the profession, may be sent direct to this Office.

Letters, whether intended for publication or private information, must be authenticated by the names and addresses of their writers, not necessarily for publication.

We cannot prescribe, or recommend practitioners.

Local papers containing reports or news-paragraphs should be marked.

Lectures, original articles, and reports should be written on one side only of the paper.

All communications relating to the editorial business of the journal must be addressed "To the Editor."

Letters relating to the publication, sale, and advertising departments of THE LANCET *to be addressed "To the Publisher."*

SANITATION IN HOTELS.

DR. C. R. AGNEW contributes to the *New York Medical Record* of Dec. 24th an interesting letter, describing some personal experiences encountered, and reflections formed, on his journey from Sandford to Jacksonville. Amongst observations general and sanitary occurs the following remark, which has a certain interest for Londoners, now that huge hotels are becoming the fashion. "Few people," says Dr. Agnew, "like ventilation, and the majority of the occupants of an hotel demand the exclusion of fresh air from halls, corridors, dining- and sitting-rooms, and prefer to live in an atmosphere which would poison a toad. At all sanitaria hotels should be built upon the cottage plan, and those enormous dining-rooms, in which hundreds of human beings congregate to feed, and meanwhile pollute each other with crowd-poison, abolished. In all large cities such huge hotels are, perhaps, necessary evils; but the day will come when, even there, more open fireplaces and new methods of forced ventilation, and the providing of baths and waterclosets for common use in detached portions of the building, will lessen the evils of the present congregate plan."

J. McK.—We are not aware of any difference in social status. The question of expense is one which depends very much upon the individual.

Dr. C. Dannegger.—The only advice we can give is for our correspondent to apply to a medical agent.

TREATMENT OF PULMONARY TUBERCULOSIS.

To the Editor of THE LANCET.

SIR,—Will you kindly insert a few lines on what I at present believe to be a new form of attacking pulmonary tuberculosis in the earlier stages. Some years ago I succeeded in affording much relief to the cough by giving the patient every half hour alternate doses of sulphate of copper and sulphate of zinc—1-50th of a grain. Without the exhibition of other drugs the cough gradually gave way, but the cases were bad to keep under observation, being of the pauper class, at their own homes. Perhaps some of your readers who are attached to institutions may think fit to try the treatment where they would know it was properly carried out.

I am, Sir, yours obediently,

Caledonian-road, Dec. 5th, 1881. WHITEWAY WILKINSON.

SMOKING IN HOSPITALS.

Mr. Henry H. Bottomley.—The question whether some of the patients in hospital should be allowed to smoke has been several times raised in discussion. Curiously enough it is only in London there seems to be any doubt on the subject. In the best provincial hospitals patients who are considered likely to benefit by smoking—for example, certain asthmatical cases and some cases of great suffering which seems to be relieved by a pipe, e.g., stone in the bladder, &c. &c.—are permitted to do so either in a suitable convalescent ward or in the grounds of the building. Obviously such a permission must be expressly given by the medical officer, and it should be so carried into effect as not to cause annoyance to other patients or to excite the envy of those who simply desire to smoke as a matter of fancy, and would be better without it. We see no difficulty in making regulations for the use of this "comfort" without any danger of its abuse.

"HANDY SYSTEM OF MEDICAL BOOK-KEEPING."

To the Editor of THE LANCET.

SIR,—In your review of my "Handy System of Medical Book-keeping" last week, you say, "To our thinking, book-keeping in medical practice may be reduced best by keeping an account of the visits and the consultations at home. Special visits and special services may be noted. . . . . The essential thing is to add them up and make any reasonable addition to the cost of drugs, &c." This is the very thing I have endeavoured to carry out, and if you look carefully at my System I think you will see that your remarks might fairly be put to it as a "preface."

I am, Sir, yours faithfully,

Cardiff, Jan. 4th, 1882. ALF. SHEEN.

EXAMINATION FOR THE LICENCE OF THE ROYAL COLLEGE OF PHYSICIANS OF LONDON.

(Third Part, or Final.—December, 1881.)

Principles and Practice of Medicine.

1. To what dangers are persons exposed who have varicose veins? Describe them severally in detail, and state how you would endeavour to prevent them.
2. Give the symptoms of angina pectoris, its pathology and treatment.
3. Enumerate and illustrate the conditions which are known to promote the invasion of phthisis pulmonalis.
4. Describe the physical signs, symptoms, and pathology of mitral obstructive disease.
5. Describe the etiology, pathology, and symptoms of sanguineous apoplexy.
6. Give an account of asthma, and its treatment.

Principles and Practice of Surgery.

1. Enumerate in their order the tissues cut through in a case of strangulated femoral hernia; mention the boundaries of the femoral ring, the direction in which the stricture should be divided, and the reason for this direction differing from that in stricture of inguinal hernia.
2. What are the symptoms and causes of hæmatocele, and the treatment to be adopted for its relief?
3. How may an impacted fracture of the neck of the thigh bone be diagnosed from one within the capsule without impaction? Describe the treatment in each case.
4. What are the causes, symptoms, and treatment of a varicose aneurism?
5. Enumerate the complications of a fracture of the pelvis, and describe the treatment of each.
6. Under what circumstances may tracheotomy be required? Describe the operation.

Midwifery and the Diseases of Women.

1. Describe the structure and relations of the decidua vera. Mention the diseases to which it is liable.
2. What are the varieties of prolapse of the uterus and vagina What would be your treatment for each variety?
3. Mention the conditions which may produce albuminuria in pregnant and parturient women. What pathological events are liable to occur in this association, and how would you act with the view of averting such events?
4. To what causes may delay in the third stage of labour be due? How would you distinguish between them, and what treatment would you adopt in each case?
5. What are the chief causes of hæmorrhage after complete delivery? Describe the treatment you would pursue and the theory of the action of the remedies.
6. For what conditions would you induce premature labour? Describe minutely the method you would adopt.

O. P. Q.—Our correspondent should consult the memorandum on disinfection, issued by the Local Government Board, and act upon the instructions he will find there. If he will address a request to the Secretary of the Board, Whitehall, London, S.W., a copy will no doubt be sent to him.

M.R.C.S. Eng.—The practice of midwifery requires, in a legal sense, no qualification.

THE FRENCH IN TUNIS.

THE correspondent of the *Daily News*, writing from Tunis, in a letter dated January 2, described his visit to the principal hospital at the Villa Kereddine. He says:—"Only five invalids, officers, the physicians, and the sanitary staff, occupy the palace. Six hundred invalids who have been sent to Bona, Philippeville, and Marseilles, were its last inmates. Nine wooden barracks have been constructed. They contain eighty invalids, who, owing to their serious state, cannot be sent home. They suffer from typhoid and dysentery. Those suffering from diphtheria are kept in a separate building. The epidemic diminished when the system of separation was adopted, but it proved fatal in the greater number of cases. Nine new barracks are being constructed. The principal ambulances are placed at Sousa, Sfax, Gabes, Gerba, Gardimaa, Béja, Kef, Testour, and Tabarca. Invalids resort in great number from every part, but which province gives the greatest number cannot be ascertained yet. Dr. Chartier, the chief physician of the hospital, and Dr. Dupouché have very kindly accompanied me through my visit and supplied me with all the details. Dr. Chartier is a distinguished physician. He assists the invalids with fatherly affection, and rarely leaves the hospital."

DEAF-MUTISM.

To the Editor of THE LANCET.

SIR,—In the review of Dr. Hartmann's work on Deaf-mutism, translated by Dr. Cassells, which appeared in your issue of the 3rd ult., the writer says "those who have specially studied and who have been engaged in teaching the deaf and dumb are not quite agreed upon the subject" (i.e., their education). Now, true there has been a difference of opinion between teachers as to the most convenient method for education of the deaf and dumb. The best and most serviceable is unquestionably that which makes them nearest akin to hearing persons—in mind, body, and general habits. All this is effected by the "German" system, or, as it is now termed in England, the pure oral. The opponents of this admirable method contend that, however good it may appear in theory, it is productive of very indifferent practical results. This contention is quite unassailable when an adaptation of the method is attempted by those very individuals, for the simple reason that they know little or nothing of the *modus operandi*, but adulterate the little they may know out of all possible recognition by means of signs and finger-spelling. I think the following facts cannot fail to satisfy the medical profession and the general public that the pure oral system will be the method of the future, and one by which dumbness will be virtually abolished. Less than fifteen years ago this system was practised only in Germany, Holland, and Austria. Now it has been established in Switzerland, Belgium, Italy, France, Norway, Sweden, Russia, Spain, Brazil, New Zealand, Australia, Canada, the United States, and Great Britain. In France, the great stronghold and birthplace of the sign system, a complete change is being effected. The International Congress on the Education of the Deaf, held at Milan last year, declared by an overwhelming majority (160 to 4) "That the oral method ought to be preferred to that of signs for the education and instruction of the deaf and dumb." With regard to the objection urged in your review that all but insurmountable difficulties often present themselves in the teaching of speech to deaf-mutes, I may point out that these difficulties are confined to such afflictions as blindness, imbecility, and paralysis, which conditions are rare in conjunction with deafness in early years. Cleft palate or any extensive malformation of the organs of articulation would undoubtedly affect the quality of pronunciation, just as it would in the case of hearing persons similarly afflicted. Supporters of the "German" system maintain, and with perfect reason, that, with the few exceptions before cited, any deaf child capable of learning written language can acquire spoken language as well. It is extremely gratifying to find medical men interesting themselves in the educational treatment of the deaf and dumb, and we cannot but believe, when once the fact is appreciated that dumbness is a manufactured affliction, the medical profession will lend its powerful aid in rescuing a large class of the community from a state of exile and deprivation, which have been brought about either by inexcusable ignorance or groundless prejudice; for it is well known to the teaching profession in this country that during the past hundred years or more Germany has recognised the fact, and acted upon it, that dumbness is not a legitimate consequence of deafness, but generally of neglect.

I am, Sir, your obedient servant,

ARTHUR KINSON,
Principal, Training College for Teachers of the Deaf.
Elmhurst, Castlebar-hill, Ealing, W.,
Dec. 1881.

Beta.—An application should be made to some institution like that at Earlswood. Papers will then be sent, and possibly something may be done. If this fails, give formal notice to the relieving officer of the district that the child is an idiot not under proper protection, and he will be legally compelled to bring the case before a justice of the peace within three days. The magistrate will then probably make an "order;" but the application to Earlswood first is the better plan of procedure.

FIREPROOF ASBESTOS PAINT.

IT is said that recent experiments made with the asbestos paint have shown that when properly prepared and applied it offers an effective protection against fire, being itself fireproof. If this be the fact, the present Lord Chamberlain might signal his tenure of office by issuing a circular enjoining the use of this paint for theatrical purposes. There can be no difficulty in enforcing the order if, as stated, the paint is susceptible of being produced in all colours and shades, and also perhaps in the form of a transparent varnish. It will be a most valuable article if it should prove to possess all the virtues attributed to it. Obviously, also, the use of this paint in hospitals and sick rooms, wherein special perils of fire are necessarily incurred, will be recognised as an act of common prudence.

Dr. Kirkham.—We think, in the present aspect of the case, it would not be advisable to publish the letter.

THE ETHICS OF DISPENSING.

To the Editor of THE LANCET.

SIR,—A retired chemist and druggist lately asked me the following question:—"What is the dose of bichloride of mercury?" I replied, the usual dose is 1-12th or 1-16th of a grain. He then showed me a prescription which he dispensed more than twenty years since. The following is a correct copy:—

℞ Opii pulv., gr. iv.; hydr. bichlor., gr. iv.; confect. aromat. q.s. ut fiant pilul. ii. cap. i. cum misturæ sequentis dimidium.

℞ Quiniæ disulph., gr. xii.; acid. sulph. diluti, ℥ xv.; magnesiæ sulphatis, ʒss.; tinct. zingiberis, ʒiss.; aquæ ad ʒiii.; m. ft. mistura.

If the pill and first half of the mixture do not give considerable relief in half an hour or one hour, repeat them.

Thinking the dose of bichloride of mercury was very large, he at once went to a medical man, who advised that it should not be dispensed, and that calomel must have been intended. The writer of the prescription, who resided not more than a hundred yards from the chemist's shop, was not consulted. After full consideration, the chemist decided to dispense the medicine as ordered in the prescription, throwing all responsibility on the prescriber. On the following day the patient walked into the chemist's shop and said that he had taken one of the pills and half the mixture, but he had been very ill, and would not on any account repeat the dose.

In such a case as this I consider your remarks in a recent number of THE LANCET (Nov. 12th, page 844) point out what should be done—viz., "the prescription should be returned to the writer for revision." As I reside in the country, my books of reference are very limited; but I never heard of such a large dose of bichloride of mercury being given. According to Neligan, the dose is from 1-12th to 1-8th of a grain; but Druitt says that Gooch cured opacity of the cornea by the administration of corrosive sublimate in doses that would now be considered hazardous. He gave a quarter of a grain twice a day, and in a few days' time increased the dose to half a grain, and then to one grain. To prescribe two grains, and the dose to be repeated in half an hour or one hour, might terminate fatally. According to Taylor (on Poisons), a fatal dose under circumstances favourable to its operation may be assumed to be about three grains. I may add that the writer of the prescription has been dead several years, and was highly esteemed as a medical practitioner. I remain, Sir, your obedient servant,

Dec. 5th, 1881. MEDICUS.

BROMPTON HOSPITAL LECTURES.

WE are asked to state that henceforth the clinical and pathological material at the Brompton Hospital will be utilised for the purposes of more systematic teaching. The lectures and demonstrations which have hitherto been delivered in short courses and at comparatively long intervals, will in future be continued throughout the academical year on Wednesdays at 4 o'clock. The adoption of a fixed day and of a fixed hour will be to the advantage of many who in the past have wished to attend, but have failed to obtain information as to the special time at which lectures were delivered. The hospital regulations have hitherto precluded the admission of cases in the acute stages; it has now been decided that a proportion of the beds in the new buildings shall be exclusively devoted to the treatment of acute cases. The usefulness of the hospital in an educational sense will thereby receive an important extension.

Nero.—We must refer our correspondent to any standard work on anatomy.

A CORRECTION.

To the Editor of THE LANCET.

SIR,—In the obituary notice of Mr. W. D. Hemming, F.R.C.S., in last week's LANCET (Dec. 24th), it is said that "his knowledge of German also enabled him to assist Dr. Cassells, of Glasgow, in the translation of the first part of Professor Politzer's great work on the Ear." I have to say that when the now deceased gentleman wrote to me, voluntarily proffering his services to assist, I had already myself completed the translation of the first or part volume of my old master's work. I, therefore, declined Mr. Hemming's offer, telling him at the same time my reason for doing so.—I am, Sir, yours very truly,

Glasgow, Jan. 3rd, 1882. JAS. PATTERSON CASSELLS.

A NEW ADVERTISING DEVICE.

M. A., N.B. Camb. tells us that in a leading chemist's shop at a favourite English health resort early this year he saw in a conspicuous position on the counter a letter-box with the name of a doctor engraved above it.

H. B. L.—Such medicines are to be taken only under medical advice.

"ON A FORM OF DYSPEPSIA OCCURRING IN INFANTS."

To the Editor of THE LANCET.

SIR,—In THE LANCET of Dec. 3rd is an article of Dr. Hassall's with the above heading. Many medical men residing in the suburbs of London and in large towns have no doubt noticed that this form of dyspepsia is especially prevalent amongst very young children who are being brought up by hand in the winter, spring, and early summer months. This is due, in my opinion, to the cows being fed on grains, and the milk containing a larger quantity of casein than it does when they are turned out to grass. The matter is one for consideration, and I think some good may be done by attention being drawn to it.

I am, Sir, your obedient servant,

Kingston-on-Thames, Dec. 21st, 1881. F. P. ATKINSON.

To the Editor of THE LANCET.

SIR,—In Dr. Hassall's interesting paper (Dec. 3rd), on a certain form of dyspepsia occurring in infants, he makes no allusion to the secretion of ptyalin. In some infants it occurs at a very early period of life. Perhaps his case may have been one of these, and in such cases starchy foods or acids, instead of alkaline remedies, must be given, and the alkaline secretion of the salivary glands prevents or retards the digestion of casein. In Dr. Hassall's case may not the digestion of the casein have been caused by the starch taking up the secretion of the salivary glands, and thus allowing the casein fair play in the stomach, and not by the mechanical action suggested?—I am, Sir, yours faithfully,

E. OVERMAN DAY.

The Royal Hospital for Children and Women, S.E.,
Dec. 3rd, 1881.

Mr. W. A. Buchan.—It is very difficult to give definite answers to the questions put, so much depends upon circumstances. A medical agent may be consulted.

A Practitioner of Fifty Years' Standing will find in our present issue some remarks bearing on the subject of his letter.

Dr. Saundby.—The paper will appear in an early number.

THE TREATMENT OF CANCER OF THE TONGUE AND ŒSOPHAGUS.

To the Editor of THE LANCET.

SIR,—As this subject is occupying a good deal of attention amongst your correspondents, and various suggestions have been made as to the best mode of treatment in your pages lately, I will record a case that was admitted into the Leeds Women's Hospital soon after its foundation in 1853. A reduced, respectable lady was admitted, on the recommendation of the late Dean Hook, vicar of Leeds, president of the hospital, for general debility and inability to swallow food. She was much emaciated, and on examination of the fauces it was found that a soft lardaceous cancerous formation infiltrated the tissues, and almost entirely blocked up the entrance to the œsophagus. By introducing fluid nourishment through a gum elastic tube into the stomach she was kept alive several months. Any surgical operation would have been out of the question, and I hope surgeons will hesitate before they perform operations for cancer of the throat and œsophagus.

I am, Sir, yours obediently,

Leeds, Dec. 1881. J. INGHAM IKIN, F.R.C.S.

SCURVY.

Tyro asks: "Will any of the readers of THE LANCET kindly inform me what are the best works published on the above?"

COMMUNICATIONS not noticed in our present number will receive attention in our next.

COMMUNICATIONS, LETTERS, &c., have been received from—Professor Rutherford, Edinburgh; Professor Longmore, Netley; Sir Wm. Gull, London; Sir Henry Thompson, London; Sir W. Mac Cormac, London; Dr. Cassells, Glasgow; Dr. More, Rothwell; Dr. Campbell, Garlands; Mr. Mears; Dr. Hamilton, Hawick; Mr. W. Wickham, Plaistow; Messrs. Marcus Ward and Co.; Dr. Ewart, London; Dr. H. Martin, Boston; Dr. Cartwright Reed, Messrs; Dr. Drysdale, Liverpool; Dr. Ward Cousins, Southsea; Dr. G. Elder, Nottingham; Mr. Davies, Sherborne; Mr. M. Carteighe, London; Mr. Nevitt, Chapel Allerton; Dr. Maclagan, London; Mr. Hardman, Blackpool; Mr. C. C. Grant, Cape Coast Castle; Mr. Vacher, Birkenhead; Dr. Tatham, Salford; Dr. Burnet, London; Dr. Shortt, Erzand; Mr. S. Murphy, London; Mrs. Bedingfeld, London; Dr. Peirce, Madras; Mr. Marks, London; Mr. Padley, Swansea; Dr. D. R. T. de Lara, Seville; Mr. J. C. Lucas; Ahmedabad; Dr. Pearse, Liphook; Mr. Collyer, Enfield; Dr. Eustace Smith, London; Dr. Meadows, London; Mr. Cotterill, Rochester; Dr. Cullimore, London; Messrs. Mottershead and Co.; Dr. Ludwig, London; Dr. Ewart, London; Mr. Maclure, London; Mr. E. Owen, London; Mr. Corsellis, Wandsworth; Mr. Whipple, Kew; Dr. Khory, London; Mr. Sydney Jones, London; Mr. D. N. Parakh, Poona; Mr. C. J. Manning, London; Mr. Stedingk, London; Dr. Sedgwick, London; Mr. Canty, Liverpool; Mr. Buchan, Plymouth; Dr. Gibson, Newcastle-on-Tyne; Mr. H. A. Allbutt, Leeds; Messrs. Stent and Sons, Guildford; Dr. Clark, Folkestone; Mr. Beaman, Newton-le-Willows; The Rev. H. Calthrop, Torquay; Mr. Rowland, Richmond; Dr. Buchanan, Glasgow; Mr. Tew, Stourbridge; Messrs. Wood and Co., New York; Dr. Scoresby-Jackson, St. Hilda's; Dr. W. Ewart, London; Dr. Sheen, Cardiff; M.R.C.S. Eng.; No Bogus; Verax; Ajax; M.D., Ealing; Assistant; Z., Birmingham; A Senior Medical Student; A Practitioner of Fifty Years' Standing; A. P. T.; J. McK.; Justitia; Beta; A. W. W.; Nero; H. B. L.; &c., &c.

LETTERS, *each with enclosure*, are also acknowledged from—Mr. Hunt, Hammersmith; Mr. Parmer, Leytonstone; Dr. Redwood, Rhymney; Miss Turner, Brighton; Mr. Bones, Dover; Mr. Wright, Toronto; Mr. Adds, Dewsbury; Dr. Guppy, Falmouth; Surgeon-Major Scott, Shirley; Dr. R. Gibbons, London; Messrs. Clarke and Sons, Leeds; Mr. Brockhurst, Matlock; Mr. Edwards, Buntingford; Mr. Douglas, Cupar; Dr. Arnison, Allendale; Dr. Whitelegge; Mr. Bryan, London; Dr. O'Brian, Chester-le-Street; Mrs. Chapman, Clapham; Mr. Hall, Newbury; Mr. Uthwait, Ancoats; Mr. Stevenson; Mr. Toulmin, Warrington; Dr. Johnson, Bournemouth; Mr. Pearse, Brierley-hill; Dr. Jones, Dolgelly; Surgeon-Major Davies, Dublin; Dr. Anderson, Halstead; M. Luzet, Paris; Mr. Stride, Brighton; Dr. Mouser, New York; Messrs. Bedford and Co., London; Mr. Wilson, Hallingden; Mr. Caulwell, Shotts; Mr. Jaudison, Middlesbro'; Major Wheatly, Dover; Mr. Montgomery, Storrington; Mr. Jennings, Coleford; S.; J. W. M.; H. G., Balham; Norval; D., Mumbles; N. E.; W. E. B., Camberwell; Edgar, Borth; H. E. H., Cheltenham; Assistant, Preston; M. R. E.; M.D., Glasgow; M.D., St. Ives; Nimrod; E. F., Scarborough; Medicus; Surgeon, Southwark; W. E. L.; Nolens Volens; &c., &c.

Church Standard, Surrey Advertiser, Family World, Australasian Medical Gazette, Morningside Mirror, Chard and Ilminster News, Insurance Press, Medical Temperance Journal, Liverpool Daily Post, Nottingham Daily Guardian, Nottingham Journal, &c., have been received.

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